St. Louis Psychiatric Rehabilitation Center

Plan for Professional Services

CY 2018

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EXECUTIVE SUMMARY

St. Louis Psychiatric Rehabilitation Center (SLPRC) is a state funded 180 bed, long-term inpatient treatment psychiatric facility operated by the Missouri Department of Mental Health's (DMH) Division of Behavioral Services (DBH). The staff at SLPRC provide an array of mental health services to a population primarily comprised of adults 18 years and older who have been committed to the Department of Mental Health by a criminal court under the mental health provisions of Chapter 552 of the Revised Statutes of the State of Missouri (RSMo) either upon their adjudication as Not Guilty by Reason of Mental Disease or Defect (commonly known as NGRI) or a finding of Permanent Incompetence to Stand Trial (commonly known as PIST). In addition, SLPRC serves a smaller cohort of adults with severe and persistent mental illness, whose admission status is voluntary by guardian, but who are extremely treatment refractory. Each of these populations typically presents with substantial deficits in the management of the symptoms of mental illness, and/or a predilection to high risk behaviors associated with a significant probability for psychiatric relapse and criminal offense, and/or a general inability to comport themselves without substantial risk to their safety or that of the community. Co-morbid substance abuse and/or personality disorders are common complications, as is clear evidence of impairment in social role functioning and daily living skills. Many of the patients, particularly those not adjudicated NGRI, are likely to have required multiple inpatient admissions with a demonstrable inability to be successful in the community, even with enhanced community-based services and residential supports. All patients admitted require intensive treatment and psychosocial rehabilitation services to develop an adequate relapse prevention plan, and to achieve the psychiatric stability necessary for discharge from hospital-based care and for safe and successful reintegration into the community. In addition, those who have been adjudicated Not Guilty by Reason of Mental Disease or Defect (NGRI) can only be released by meeting specific legal standards as approved by a judge.

In 1993, the Director of the then Division of Comprehensive Psychiatric Services (CPS) appointed a state-wide Psychosocial Rehabilitation Task Force and charged it implement the evidence based and recovery based psychosocial rehabilitation technologies most appropriate to the clients then under care of each of its long-term inpatient psychiatric treatment facilities. The most comprehensive design and implementation of such programming took place at Fulton State Hospital and SLPRC, which continued to evolve and refine those technologies based on changes in the client population, input from client and staff, data collected at the facility, subsequent division wide assessments in 2003 and 2007, a reconfiguration of all the DMH hospitals as part of a Division-wide Inpatient Redesign initiative in 2011 and 2012, and a continuous review of new information available from the professional literature.

At the present time, the programs implemented at SLPRC include the following:

- Social Learning – for individuals with the most profound deficits associated with severe and persistent mental illness and long-term institutionalization.

- Illness Management and Recovery – for individuals whose response to treatment suggests a high potential for semi-independent or independent living in the community, once otherwise determined to be appropriate for release.
- TruThought/Cognitive Behavior Program – for individuals whose readiness for release is compromised by criminal thinking patters and behaviors.
- Dialectical Behavior Therapy – for individuals with severe emotional dysregulation disorders
- Deaf Services – for clients who are deaf and whose response to treatment is greatly enhanced through the provision of a culturally affirmative program specifically designed for deaf individuals

March 03, 2018

MISSION

What We Do: Provide quality long-term forensic inpatient treatment and psychiatric rehabilitation

For Whom: Missourians who are recovering from a serious and persistent mental illness for which they were criminally committed

Why We Do It: To enable those we serve to safely return to the community so they can love, learn and work and have meaningful lives

VISION

"Excellence in Service of Recovery"

On behalf of those we serve, we are dedicated to provide excellence in all we do

VALUES

P – partnership
R – responsiveness
I – integrity
D – dignity
E - empowerment

Partnership

We believe in partnership
- among clients served, their families & friends, staff & community providers
- with the communities we serve primarily in the Eastern Region
- that stresses communication across all levels of the organization
- that bridges cultural differences that might otherwise divide us
- that supports & maximizes the range of available choices for our clients

Responsiveness

We support an array of services
- that are accessible
- that validate our clients' needs, requests and concerns
- that are culturally competent
- that are tailored to individual needs and goals
- that encourage hope, engagement in treatment, and increased freedom within our hospital
- that enable clients to succeed by achieving a meaningful life in the community

Integrity

We expect ourselves to be accountable
- to deliver the best possible outcomes effectively and compassionately
- to provide the tools, training &resources needed by staff to do their jobs safely and well
- to use funds and resources responsibly & to be good stewards of the public trust
- to recognize & celebrate excellence in all our staff
- to provide the follow-up & transition services necessary for community success
- to advocate tirelessly for those who struggle with mental illness, developmental disability, or substance abuse/addiction

Dignity

We recognize the aspirations of our clients
- for respect & dignity
- to fulfill hopes for growth, change & recovery
- to achieve a balance among choice, personal responsibility & socially acceptable behavior
- to increase their independence and freedom of movement within our hospital
- to live as they choose within the limitations of the legal system & public safety in the most independent environment possible
- to be treated sensitively in respect to their trauma history

Empowerment

We value clients' ability
- to direct their lives & act on their own behalf
- to use their individual talents & resources
- to make choices in keeping with their values and goals
- to work productively
- to improve the quality of their lives
- to achieve their own personal recovery

PHILOSOPHY

The Missouri Department of Mental Health is dedicated to the establishment and on-going maintenance of a balanced mental health service system that is focused on "Hope, Opportunity and Community Inclusion", ensuring that Missourians who receive mental health services "will have the opportunity to pursue their dreams and live their lives as valued members of their community ." In pursuit of that vision, the Division of Behavioral Health endeavors to target a population comprised of severely emotionally disturbed children, forensic clients, and adults with severe and disabling mental illness. SLPRC shares this mission for the latter two populations within its geographic area of responsibility.

St. Louis Psychiatric Rehabilitation Center's philosophical foundation is that recovery based rehabilitation programming designed to meet quality standards decreases the potentially disabling effects of mental illness, enabling clients to return to the community and exercise a normalized range of choices without endangering public safety.

It is the conviction of St. Louis Psychiatric Rehabilitation Center that each of its programs be evidence based, grounded in sound theory and research with similar populations and dysfunctions. Because of the long-term and often treatment resistant nature of the SLPRC's population, it is believed that such an approach is essential to produce the outcomes desired for its clients.

Integral to our efforts are the following key concepts: (1) a commitment to the empowerment of our clients and the recovery goals that they formulate for themselves; (2) an emphasis on the achievement of desired client outcomes as the ultimate arbiter of the efficacy of the rehabilitation methodologies both in concept and implementation; (3) the establishment of linkages with community-based agencies necessary to achieve and maintain those outcomes; (4) the preservation of public safety; (5) the involvement and empowerment of employees within all levels of the organization in the planning, implementation and improvement processes; and (6) a physical and social environment designed to support our rehabilitation efforts and sufficient to address public safety concerns.

Services are provided within a humane and therapeutic environment and, where possible, in the least restrictive setting appropriate to the needs of the individual and public safety considerations. Services are provided without regard to race, sex, creed, marital status, national origin, age, sexual orientation, disability or gender preference.

STRATEGIC PLANNING AND PERFORMANCE IMPROVEMENT

The purpose of strategic planning is to determine organizational priorities and goals, to communicate those priorities and goals throughout the facility, and to provide a framework within which more detailed planning and operationalizing of plans can take place. Strategic planning begins with the Missouri Department of Mental Health's Strategic Plan, which drives the Eastern Missouri Psychiatric Hospital System Strategic Plan (EMPHS), which, in turn, drives the St. Louis Psychiatric Rehabilitation Center's Strategic Plan. St. Louis Psychiatric Rehabilitation Center's Executive Committee has primary responsibility for strategic planning for the facility, although many groups at all levels of the hospital participate in the process by providing input to facility leaders and concretizing specific elements of the plan. In addition, input is obtained from other key stakeholders, including clients, families and friends, and the community providers of mental health services.

The strategic planning process consists of the basic stages listed below:

I. Mission, Vision, Values provide guidelines for all organizational planning and priority setting activities.
II. Strategic Initiatives (AKA "Issue Statements") set broad, long term priorities over either a 3 or 5 year Strategic Planning Cycle, and are modified as necessary throughout the Cycle.
III. Objectives, Strategies, Responsible Parties, and Anticipated Outcomes, all of which operationalize the deliverables inherent in the Strategic Initiatives.

Each of these elements is discussed in greater detail below.

The Executive Committee has a special responsibility for defining the facility's mission, vision, and values. In defining these, facility leaders consider input from a variety of sources, with particular emphasis on the mission, vision, values and policies of the Department of Mental Health. Reference is also made to relevant Missouri statutes, needs assessment data, and the views of key stakeholders. After being defined, the mission, vision, and values of the facility guide all other planning and priority setting activities.

The Strategic Initiatives, and their components, including Objectives, Strategies, Responsible Parties, and Anticipated Outcomes, represent the hospital's Strategic Plan. They are the culmination of a Strategic Planning process that includes broad representation from among the hospital workforce at all levels, and is driven by hospital leadership. The Strategic Plan represents a broad facility consensus regarding the hospital's priorities, following a careful analysis of its internal Strengths and Weaknesses, and any external Opportunities or Threats. The Strategic Plan is not formulated in isolation, but within the context of other larger, planning efforts, including

those of the Department of Mental Health, the Division of Behavioral Health, and planning specific to the EMPHS, and includes a review of plans or reports from other bodies (any statewide committees or advisory groups addressing applicable topics), internal program or department plans and requests, input from other stakeholders (e.g., clients, families, community providers), and the results of various performance improvement activities.

Improvement priorities are based on the assessment of key performance measure data (such as client satisfaction data, Quarterly Scorecard, etc.) and priorities recommended by SLPRC Treatment Programs, Departments, Root Cause Analysis Teams, Hazard Vulnerability Analyses, and Robust Process Improvement Teams. Each Treatment Program's Program Director, each Clinical Department's Director, and each Robust Process Improvement Team reports on an ongoing basis to the hospital's Executive Committee (supplemented by the hospital's Morning Meeting Committee, whose membership includes the Chief Operating Officer, Medical Director, Chief Nurse Executive, Director of Clinical Services, Program Directors of all treatment programs, and Directors of Social Work, Psychology and Rehab Services. The Executive Committee analyzes the data and updates the facility's Strategic Plan based on the results of the analysis.

The Appendices of this Plan includes a report of the results of the last Strategic Planning Cycle, from CY13 through CY17, and a Draft of Plan for CY18 through CY23. That draft will be finalized and implemented over the course of FY2018.

HISTORY, CONTEXT AND DIRECTION

In 1993, the Department of Mental Health developed a Comprehensive Plan for Adult Psychiatric Services that is consistent with the dictates of Public Law 99-660 and the State of Missouri response to Olmstead v. L. C. (98-536). The thrust of the plan was to develop an integrated and community-based system of mental health services for individuals with forensic histories and severe and persistent mental illness. The goals of the plan most relevant to SLPRC were: (1) to facilitate reintegration of clients into the community in a manner supportive of public safety and, (2) to provide inpatient psychiatric services on a continuum of care basis, with long-term psychiatric hospitalization reserved for criminally committed clients and for those few clients whose recent behavior precludes their placement in the community.

In support of these goals, the Department took the initiative to down-size St. Louis Psychiatric Rehabilitation Center with an accompanying redirection of budgetary allocations to the Administrative Agents and to build a more energy-efficient and cost-effective facility conducive to rehabilitation efforts. The mission of long-term psychiatric facilities, including SLPRC, was redefined as providing psychosocial rehabilitation to a primarily forensic population.

State Psychosocial Rehabilitation Committee and Inpatient Redesign

One outgrowth of the above initiative was the formation of a State Psychosocial Rehabilitation Committee that met between 1993 and 1996. The Director of the then Division of Comprehensive Psychiatric Services (now the Division of Behavioral Health) gave this committee the charge to review the needs of the population who remained in the long-term care facilities. The committee determined which rehabilitation and recovery technologies would best serve the needs of the clients and developed a plan for implementing and refining the technologies at each facility.

During the Fiscal Years 2004 through 2006, SLPRC conducted a comprehensive Needs Assessment for the facility, prompted by the length of time since the previous Needs Assessment was done, the perception that the facility's population distribution had changed, budget cuts within the Department of Mental Health, and the hiring of a new Regional Executive Officer for the Eastern Missouri Psychiatric Hospital System. The results of the Needs Assessment indicated a change in the percentage of clients requiring the programming the various treatment programs offered at SLPRC and prompted a reorganization of the facility. The process of assessing the needs of the client population and the appropriateness of the various elements of the formalized treatment programs is a continuing process.

In March 2007, a state-wide committee was reconvened to conduct an ongoing review each facility's client population, their treatment and rehabilitation needs and programming offered to address those needs. This review has confirmed the need to

continue current programming as well as indicated the need for some facilities, including St. Louis Psychiatric Rehabilitation Center, to add some specialized treatment modalities, such as Dialectical Behavior Therapy and Deaf Services programming.

Each of the aforementioned efforts were in turn shaped and reshaped by the Department's Inpatient Redesign initiative, which dramatically reconfigured each of the department's psychiatric hospital in response to state-wide budget cuts in Fiscal Years 2011 and 2012. This resulted in the elimination of acute care psychiatric beds, and the conversion of the hospitals containing such beds to long-term inpatient psychiatric hospitals. Thus was done to enable the acceptance of clients transferred from Fulton State Hospital as a result of a dramatic reduction in its intermediate security beds.
The cumulative impact of these changes produced the programmatic organization and distribution we see today.

Security Review Task Force

An additional development in 1996 and 1997 was the statewide initiative on security issues as they apply to long-term care, primarily forensic facilities. In August, 1996 the Department Director formed a Security Review Task Force precipitated by the unauthorized absence of several forensic clients from various facilities and expressions of concern from the community regarding public safety. The recommendations that emerged from this task force called for a redesign of risk assessment tools, physical environment, policies and procedures. The specific recommendations were as follows: (a) developing four levels of security for forensic clients from Maximum Security, through Intermediate Security, to Minimum Security, to Open Campus settings; (b) revising the Risk Rating System governing privileges and passes to include full consideration of historical information regarding criminal charges and serious incidents, in addition to current behavior patterns; and (c) standardizing policies and procedures across all forensic programs and settings. These recommendations have been implemented and continue to be used to date.

SLPRC provides Minimum Security and Open Campus settings, as described in the Security Review Task Force Report. Minimum Security entails perimeter fencing and locked wards within that perimeter, and requires supervision of any client on that level of security when outside the perimeter. By contrast, Open Campus settings are outside perimeter fencing and enable residents to have unsupervised privileges. Authorization of various privilege levels is subject to external review and approval by the Chief Operating Officer through a Risk Assessment process developed by the four long-term care facilities and standardized across each.

Status of Program Implementation at St. Louis Psychiatric Rehabilitation Center

Cognitive Behavioral Program (CBP): The Cognitive Behavior Program consists of Ward E and Cottages A and 10 (see "Programs" for additional information, and the Program Manual for specific details). The purpose of the program is to address the specialized needs of clients whose symptoms of serious mental illness may be in partial or complete remission, but who continue to present significant behavioral challenges secondary to personality disorders with substantial Antisocial and/or Narcissistic features which make it difficult for them to obtain their conditional release and avoid the high risk behaviors associated with psychiatric relapse and/or criminal reoffending. The program is the hospital's oldest, beginning in September of 1991 with substantive implementation since July of 1995. In October of 2015, a program realignment effort resulted in the program contracting by 16 secure cottage beds, but assuming responsibility for 8 campus security cottage beds to provide for greater continuity of care and to reduce length of stay. The Cognitive Behavioral Program continues to assist clients with identifying maladaptive thinking patterns that contributed to antisocial and criminal behavior, as well as with encouraging clients to accept personal responsibility for their actions.

New Outlook Program (NOP): The New Outlook Program was designed for people who exhibit challenging behavior during episodes of mood dysregulation, often displaying aggression, self-harm, or sexual acting out, sometimes coupled with substance abuse to in an effort to manage their emotional distress. The New Outlook Program assists people to better understand the function of their behavior and to learn more adaptive strategies for emotional regulation. The program is one of the hospital's newest, beginning in 2009, and is currently housed on Ward F, Cottage B, and Cottage 12. The program realignment initiative described above resulted in the program's growth of 16 cottage beds.

Social Learning Program (SLP): The Social Learning Program was implemented on an incremental basis beginning in June of 1996. It involves an intensive application of learning theory and behavioral principles for individuals who have substantial behavioral and social deficits as a function of severe, persistent and treatment refractory mental illness, and/or neuro-cognitive deficits secondary to closed head injuries or diffuse neurological damage, and/or the debilitating effects of long-term institutionalization. The program crosses the security continuum from minimum to open campus to provide a continuum of care that best prepares clients for transition to the community and the gradual withdrawal of a highly structured token economy to more naturalized reinforcers. The program is currently housed on Wards G and H and Cottages 6 and 8.

Transitional Rehabilitation Program (TRP): The psychiatric rehabilitation program at SLPRC was named the Transitional Rehabilitation Program (see "Programs" section for general description). The purpose of the program is to provide clients the skills and resources needed to manage their mental illness in independent and semi-independent community settings. The program was implemented on an incremental basis beginning in July, 1994 and completed in August, 1995. The Transitional Rehabilitation Program consists of three cottages (Cottages 2, 4, and D). The program realignment initiative described above resulted in the program reducing by 16 campus security beds, while

assuming responsibility for 8 minimum security beds to ensure continuity of care across security levels.

Deaf Services: The deaf services program is a hybrid of both minimum and campus security located in Cottage C. It serves Deaf and Hard of Hearing clients who have mental illnesses and require intermediate to long-term inpatient treatment to address emotional, behavioral, and communication challenges. It offers a therapeutic approach that is affirmative of Deaf Culture, and offers an environment that is both socially and environmentally designed to meet the specific needs of Deaf and Hard of Hearing clients. The Deaf Services program must treat clients whose clinical presentations are very diverse, other than being inclusive of hearing loss, with many demonstrating a wide variety of language, emotional and behavioral challenges, many of them severe in nature. This requires a programming approach that is eclectic and generalist in nature, targeting the individual and heterogeneous treatment needs of each client, encompassing a range of therapeutic approaches, including cognitive behavior therapy, illness management and recovery, and behavior therapy.

Centralized Services (CS):
Centralized Services consists of a diverse group mental health providers who offer a variety of interventions available to clients throughout the facility. CS is comprised of Central Activity Therapy and Client Work Program. Each of these programs offers services to clients across all of the residential programs. The purpose of CS is to provide interventions in order for clients to meet treatment/rehabilitation including forensic issues related to risk, as well as client needs in terms of leisure/recreation, vocational/work skills, and deaf interpretation.

CLINICAL NEEDS OF THE COMMUNITY

Description of the Population

The vast majority of our clients at any given point in time are individuals who have been committed by the circuit courts of St. Louis and its surrounding counties for psychiatric treatment related to the commission of a crime. Most of these clients, and most of the remainder of our non-forensic population, suffer from a severe and disabling mental illness, yet exhibit all the diversity of the general population in terms of backgrounds, needs, goals, motivations, strengths, and disabilities.

Diagnoses of Population

The major mental illnesses of clients at SLPRC include the schizophrenias and affective disorders (e.g., bipolar disorder, depression with psychotic features). These mental illnesses, or as they are referred to in the Missouri statutes "mental diseases", are generally of long duration, and episodic in nature. Periods of decline in functioning often result in unemployment, poor job histories and/or limited job skills. People with mental illness often need public financial assistance but lack the skills necessary to obtain benefits and entitlements on their own. Further, they are often isolated and have inadequate social support which contributes to their vulnerability to stressors. In addition, they may have a history of poor compliance with psychotropic medication. Despite the deficits and problems experienced by these individuals, most can achieve an improved quality of life and become productive citizens with access to appropriate services and supports.

Within the population at SLPRC, there are also diagnostic subgroups of clients with special needs that must be taken into consideration when designing and implementing services. Subgroups include clients who abuse alcohol or drugs, those who have personality disorders, and those with dual diagnosis of mental illness and mental retardation. Each of these groups requires intensive and specialized services delivered by well-trained staff. Many of these clients have difficulty meeting the criteria for release because, for example, clients with personality disorders engage in behaviors that bring them into repeated conflict with society and clients who abuse substances are engaging in illegal behavior and at an increased risk for dangerous behavior.

Population Description by Primary or Principal DSM5 Diagnoses (as of 03/07/18)

Diagnostic Category	Total # of Diagnoses	% of Total Census
Severe & Persistent Mental Illness (SPMI)	**74**	**43.0%**
Schizophrenia Spectrum/Other Psychotic Disorders	*44*	*25.6%*
Bipolar & Related Disorders	*22*	*12.8%*
Depressive Disorders	*5*	*2.9%*
Anxiety Disorders	*1*	*0.6%*
Obsessive Compulsive and Related Disorders	*2*	*1.2%*
Substance-Related Disorders	**54**	**31.4%**
Alcohol	*20*	*11.6%*
Cannabis	*16*	*9.3%*
Cocaine	*6*	*3.5%*
Opioid	*6*	*3.5%*
Hallucinogen	*1*	*0.6%*
Inhalant	*2*	*1.2%*
Other Psychoactive Substance-Related Disorder	*3*	*1.7%*
Personality Disorders	**18**	**10.5%**
Borderline Personality Disorder	*2*	*1.2%*
Antisocial Personality Disorder	*9*	*5.2%*
Other Personality Disorder	*7*	*4.1%*
Neurodevelopmental & Neurocognitive Disorders	**17**	**9.9%**
Intellectual Disabilities	*16*	*9.3%*
Neurocognitive Disorders	*1*	*0.6%*
Trauma and Stressor-Related Disorders	**5**	**2.9%**
Paraphilic Disorders	**1**	**0.6%**
Other Diagnoses	**3**	**1.7%**
	176	**100%**

Legal Status of Population

Most SLPRC clients not only have a diagnosis of a mental illness, but are also part of the forensic system, which means that they were committed to SLPRC through the courts and can only be released through the courts. The majority of clients are committed to the Department of Mental Health after having been found Not Guilty by Reason of Mental Disease or Defect (NGRI). A smaller but growing population of forensic clients is committed to the Department after a finding of Permanent Incompetence to Stand Trial and assignment of a guardian. If committed for a major offense, the clients are first hospitalized at the high security hospital of Fulton State Hospital, later transferred to SLPRC if no longer requiring that level of security and from the Eastern Region. If committed for a non-major offense, clients are directly committed to SLPRC. These clients committed as NGRI remain in the facility for care and treatment, until such time that they meet the legal standard for release and are granted a release by the appropriate court.

Service/Catchment Area Description

Founded in 1869 as the St. Louis County Insane Asylum, and later known as the St. Louis City Insane Asylum and St. Louis City Sanitarium, the hospital was purchased by the State of Missouri in 1948. St. Louis State Hospital has moved from an inpatient population high of slightly under 4,000 during the period from 1942-1948 to the current 180 beds.

St. Louis Psychiatric Rehabilitation Center (SLPRC) is owned by the State of Missouri and operated by the Department of Mental Health of the State of Missouri. St. Louis Psychiatric Rehabilitation Center shares its 55-acre campus with the Regional Office of the Division of Behavioral Health, and two cottages operated by the Places for People Community Mental Health Center, a provider for the Division of Behavioral Health. In addition, SLPRC has made room on its campus for a YMCA and the St. Louis Charter School.

Table 1: Counties Served

County	Population	Service Area
Adair	25,607	14
Audrain	25,529	15
Callaway	44, 332	15
Clark	7,139	14
Franklin	101,492	16
Jefferson	218,733	22
Knox	4,131	14
Lewis	10,211	14
Lincoln	12,761	16
Macon	15,566	14
Marion	28,761	14
Monroe	8,840	15
Montgomery	12,236	15
Pike	18,516	15
Ralls	10,167	15
Saint Charles	360,485	16
Saint Louis	1,000,438	23
St. Louis City	319,294	24/25
Schuyler	4,431	14
Scotland	4,843	14
Shelby	6,373	14
Warren	32,513	16
TOTAL	**2,228,066**	

As indicated previously, the majority of clients admitted are through a criminal court commitment (RSMo. 552). However, a smaller percentage of clients served have been admitted on either a civil involuntary commitment bases (RSMo. 632), or as Voluntary by Guardian – never forensic (RSMO.475), when in the opinion of the Department's providers of community based treatment, such clients have exhausted all safe available treatment options in the community and are in need of an extended inpatient hospital stay, beyond the capacity and capability of most community hospitals with psychiatric units.

Table 2: Service Area Population

Service Area Population	Service Area
107,062	14
75,288	15
507,251	16
218,733	22
1,000,438	23
319,294	24/25
2,228,066	**Total**

St. Louis Psychiatric Rehabilitation Center serves clients 18 years and older, from a catchment area of the Eastern and Northeastern Regions of the State of Missouri (see Figure). The counties included are 22 in number, with a total

population of 2,228,066, and comprise Service Areas 14, 15, 16, 22, 23 and 24-25, as designated by the Missouri Department of Mental Health (see Tables 1 and 2).

Figure 1

Hours of Operation

St. Louis Psychiatric Rehabilitation Center provides 24-hours a day, 7 days a week, long-term psychiatric rehabilitation services.

Description of Physical Plant

Located within the campus, St. Louis Psychiatric Rehabilitation Center utilizes the major portion of the buildings:

1. The Main Building contains four wards with a capacity of 100 clients. Two wards are assigned to the Social Learning Program, one ward is assigned to the Cognitive-Behavioral Program, and one ward is assigned to the New Outlook Program. Each ward has three pod areas and each client has an individual room, with a bathroom adjoining the room of one other client. In addition, it also contains the Gymnasium, Fitness Room, Beauty Shop, Canteen, Centralized Services office area and classrooms, Client Work Program, Dietary Services, Maintenance, Property Control, Housekeeping Services, Medical Clinic, Pharmacy, Nurse Educator, Staff Development, Quality Management, Health Information Management Services, Human Resources, Volunteer Services, and offices for hospital accounting and administrative staff.

2. The 10 cottages house up to eight clients each. Each cottage has a kitchen, dining room, den, laundry room and four bathrooms. Each client has his or her own room. The cottages are assigned as follows: one for the Deaf Services Program, two for Social Learning Program, two for Cognitive-Behavioral Program, two for the New Outlook Program, and three for the Transitional Rehabilitation Program.

3. The Dome Building is not part of St. Louis Psychiatric Rehabilitation Center, proper, but is supported through St. Louis Psychiatric Rehabilitation Center. It houses in its administrative office tower (A/F and Center sections), the Offices of the Chief of Adult Community Operations, the Chief of Child Community Operations, the System of Care Programs, the Office of Information Services, and the Supportive Community Living Program, as well as the former Missouri Institute of Mental Health Library now under the oversight of SLPRC.

Organizational Structure

Treatment/Rehabilitation Teams

Delivery of mental health services to clients who require hospital or institutional care is a complex process that is beyond the scope of training of any single professional discipline. In order to evaluate, treat and rehabilitate the individual clients, an inter-disciplinary approach is required.

SLPRC supports and expects a "team treatment/rehabilitation" model of service delivery. "Team" implies that individuals are working together in an environment of mutual respect. Each member must endeavor to acknowledge and value the skills, knowledge and life experience brought to the table, whether by professionals, para-professionals, support staff, family members or the client him/herself. Wherever and whenever possible, the team should employ a consensus-seeking, decision-making model to ensure that in their collective judgment the best possible treatment and rehabilitation is being provided to the clients in their care. However, it is the responsibility of the Team Leader (see description of Team Leader under “Program Administration” section) to determine that the team is functioning as it should and is responsive to the needs of its clients, while operating in accord with the program’s methodology.

The notion of team is not limited to staff in the facility. It extends to partnerships with the client, his family and significant others, and at the time of discharge preparation to the Community Mental Health Administrative Agents and Affiliate Providers that are responsible for orchestrating the delivery of mental services within the region. When a client is admitted to the facility, the inter-disciplinary team is responsible for determining what goals or problems need to be satisfactorily resolved for the client to be safely and successfully returned to the community.

Comprehensive assessments are conducted by members of the inter-disciplinary team to identify the client's physical, social and psychological assets and deficits. At the treatment planning meeting, recommendations from assessments are discussed and integrated in the treatment plan. The client and client family are invited to participate with and as members of the team to identify problems or needs which resulted in the client's hospitalization. The nature and composition of the team depends on whether the client is admitted to the New Outlook Program, Social Learning Program, Cognitive-Behavioral Program, Deaf Services, or Transitional Rehabilitation Program.

Team Composition

The primary or core clinical team is composed of the following clinical disciplines, one of whom serves as the Team Leader: (a) Psychiatry; (b) Nursing; (c) Social Work; (d) Psychology; and (e) Rehabilitation Services. In addition to the

professionally trained clinicians, the team is composed of paraprofessionals (Psychiatric Technicians) who are trained to provide specific activities (primarily nursing), and to co-facilitate activities developed and orchestrated by the other disciplines. Centralized Services (Client Work Program and Central Activity Therapy) provide regular input to the client record and to the treatment team for those clients referred for these specialized services.

Each clinician has the responsibility to meet the requirements of the rehabilitation program as presented in the Program Manual and to provide those services consistent with the standards of the clinical disciplines described in the Discipline Standards Manual. This approach encourages clinicians to utilize their specialized training and experience. This leads to a wide variety of treatment and rehabilitation activities that are incorporated in the client's Individualized Treatment and Rehabilitation Plan (see "Assessment, Diagnosis and Treatment Planning" below).

The duties and responsibilities of each of the professional staff members on the team and those professional staff members available as needed, are described below:

A. ***Psychiatry***

The Psychiatrist is responsible for client admission and discharge, for the psychiatric evaluation and diagnosis, and for the psychiatric care of each client.

B. ***Nursing***

The Nursing Department (Registered Nurses, LPNs, and Psychiatric Technicians) is responsible for planning and implementing individualized nursing care for each client and for delivering rehabilitation activities in the general area of health maintenance activities (e.g., Medication Management, Activities of Daily Living). The LPNs and Psychiatric Technicians are also trained to facilitate recreational and socialization activities for clients on evenings, weekends and holidays.

C. ***Psychology***

The psychology department includes licensed psychologists, licensed behavioral analysts, and licensed professional counselors. These individuals provide a variety of services, including psychological testing, functional behavioral assessment, behavior management plans, substance abuse screening, psychotherapy (e.g., group, individual, behavioral psychotherapy, as well as specialty psychotherapies such as Art Therapy, Responsibility Therapy, Sex Offender Therapy, etc.), and other psychoeducational activities (e.g., Anger Management, Problem Solving, Symptom Management, etc.). In

addition, members of the department complete Integrated Risk Assessments and are responsible for supervision of psychology pre-doctoral interns, and psychology and art therapy graduate students.

D. ***Social Work***

The Clinical Social Worker provides a comprehensive assessment of the client, provides individual and group treatment and rehabilitation to the client and family, develops discharge and aftercare plans, and acts as a liaison to provide linkage with other community agencies and the courts.

E. ***Rehabilitation Services***

Rehabilitation Services includes some combination of Recreational Therapists, Music Therapists, or Dance and Movement Therapists. The Rehabilitation Services staff are responsible for conducting comprehensive assessment of vocational, leisure, health maintenance, and rehabilitation needs. Treatment and rehabilitation are provided through individual and/or group settings using didactic, task oriented, activity oriented and community out-trip methods. In addition, Rehabilitation Services provide non-treatment activities that enhance the quality of life for our clients as well as provide them with opportunities to generalize their treatment and rehabilitation goals and objectives in less structured environments.

Other Team Consultants

In addition to the consultants identified above, all programs have access to consultative services from a number of other resources in the facility:

- ***Medical Clinic***: Medical Clinic Physicians complete the initial and annual Review of Systems, a Physical Examination, a Neurological Examination, and a Medical Assessment. Medical Clinic Physicians will also be responsible for approving outside medical and surgical appointments and making arrangements for outside medical treatment when indicated. Immunizations are performed annually and as needed in the Medical Clinic. The Dentist completes a dental assessment, provides dental care, and makes arrangements for outside dental care and treatment when indicated. Additionally, the Optometrist will screen all eye services and refer those that require ophthalmology services.
- ***Dietary***: Registered Dietitians assess the client's nutritional needs and provide dietary treatment for specific illnesses upon physician or psychiatric referral.
- ***Pharmacy***: Registered Pharmacists maintain a medication profile, and provide both staff and clients with medication education.
- ***Client Work Program***: Upon team referral, Work Specialists assess client’s vocational rehabilitation needs and provide for vocational rehabilitation activities both within and outside the facility.

- ***Central Activity***: Staff the client recreation room, gym, Barber/Beauty Shop, library and fitness center and coordinate the provision of a number of recreational and diversional activities and holiday programs.
- ***Pastoral Services***: the Coordinator of Pastoral Services completes a Spiritual Assessment upon referral, and ensures that the client's faith community is a resource during discharge planning efforts; in addition, coordinates the provision of liturgical services and spiritual visitation, and is available to assist with Advanced Directives.
- ***Volunteer Services***: volunteers provide for visitation upon request and staff valuable client services such as the Canteen and Clothing Store; in addition, solicit many donations for treatment, rehabilitation and recreational purposes;
- ***Peer Specialist***: consumers of mental health services who provide current inpatients examples of the lived experience of recovery. They assist clients in developing treatment goals and objectives that ultimately result in their discharge to the community. They do so by their own experiences and by an understanding of the mental health system, both inpatient and community-based. They consult with treatment teams and clinicians regarding client care and goals, as well as serve on committees throughout the facility that enhance the quality of treatment and standard of living for clients. Their primary focus, however, is working directly with clients to instill hope and facilitate change. Peer specialists are supervised by the Director of Social Work. They receive a 5-day training sponsored by the Missouri Department of Mental Health and complete a standardized certification process.
- ***Support Service Staff***: the various departments of Supply & Purchasing, Resources, Accounting, Security, Motor Pool, Maintenance, Housekeeping and Fire & Safety collaborate with teams to provide the client with a safe, secure, and therapeutic environment; in addition, many provide work sites for clients through participation in the Client Work Program.

Administration

Consistent with Governing Body Bylaws, Hospital Governance is provided by the Chief Operating Officer, the Regional Executive Officer, the Director of Inpatient Operations, and the Deputy Director for the Division of Behavioral Health.

Regional Executive Officer

The Regional Executive Officer is responsible for oversight of all department operations within the region, both inpatient and outpatient.

Deputy Director for Psychiatric Facilities

The Deputy Director for Psychiatric Facilities is responsible for oversight of all hospitals operated by the Department of Mental Health.

Deputy Director for the Division of Behavioral Health

The Deputy Director is responsible for oversight of all community operations and for assisting the Division in oversight of all services provided to clients with mental health and substance needs.

Chief Operating Officer

The Chief Operating Officer (COO) serves as the appointing authority for the facility and is responsible for oversight of all clinical staff within the hospital and for setting the strategic direction for the hospital.

Day to day leadership of the hospital is provided by an executive team comprised of staff with facility wide responsibilities, including the Chief Operating Officer, the Medical Director, the Chief Nurse Executive, the Director of Clinical Services, the Quality Management Specialist, and Human Resource Analyst. The Program Directors are also members of the hospital executive team, as are staff with region wide responsibilities, including the Chief Fiscal Officer, the Human Resources Manager, and the Quality Improvement Director. Their roles are described as follows

Medical Director

The Medical Director is responsible for the clinical oversight of all psychiatrists, medical clinic, physicians, dentist, contract physicians, and Optometrist. In addition, the Medical Director has administrative oversight of the Medical Clinic and the Pharmacy with the Chief Nurse Executive.

Chief Nurse Executive

The Chief Nurse Executive is responsible for clinical and administrative oversight of all registered nurses, licensed practical nurses and psychiatric technicians in the facility.

Director of Clinical Services

The Director of Clinical Services is responsible for oversight of the clinical programs to improve adherence to treatment models. Additionally, the Director of Clinical Services oversees and implements special clinical projects and the Departments of Social Services, Psychology, and Rehabilitation Services.

Other Clinical Department Directors

The Directors of Social Services, Psychology and Rehabilitation Services are responsible for developing the standards of practice for their discipline, and for ensuring that those standards are met by each member of their department through supervision, monitoring, and ongoing performance improvement activities.

Chief Fiscal Officer

The Chief Fiscal Officer is responsible for overseeing the budgets of all facilities within the region and for supervising each of the support side departments.

Human Resources Manager

The Human Resources Manager is responsible for overseeing human resource staff of all facilities within the region, and for providing direction and consultation to all staff regarding recruitment, retention, workforce development, and compliance with all other personnel practices.

Quality Improvement Director

The Quality Improvement Director is responsible for all performance improvement activities and for providing direction and consultation regarding the accreditation and certification process.

The clinical leadership of each program is comprised of the Program Director, the Program Nurse Manager, the Program Psychiatrist(s) and the Team Leader(s). Their roles are described as follows:

Program Director

The Program Director serves as the chief executive of the program, and has overall responsibility for developing, implementing and evaluating the program. As such, the Program Director serves as the facility expert for the evidence based/best practice that the program delivers. In addition, he or she is responsible for overseeing the program budget, for securing resources and staff, for coordinating the program's services with the overall facility vision and values, and for ensuring that the program environment is supportive of recovery and rehabilitation efforts. The Program Director is also responsible for: (a) supervising all staff within the program; (b) developing tools for attesting to clinical competence; (c) ensuring fidelity to the rehabilitation methodology; (d) verifying the integrity of scheduled treatment and rehabilitation; (e) training staff to competence in the delivery of the rehabilitation methodology; and (g) program evaluation to assess the program's success in delivering the expected clinical outcomes.

Team Leader

The individual responsible for coordinating the activities of a treatment team assigned to a residential component of the Clinical Program. The Team Leader ensures that the schedule developed by the Program Director is implemented, redeploying and reassigning staff as needed in keeping with the needs of the schedule and the staff's clinical privileges and responsibilities. This includes the development of both staff specific schedules and client specific schedules, in keeping with the goals, objectives and interventions listed on clients' treatment plans. This individuals is also responsible for implementing with his or her treatment team any corrective actions taken by the Program Director specific to the Annual Evaluation, otherwise identified deficiencies in program fidelity, or priorities identified in performance improvement or risk management activities. The Team Leader also facilitates treatment team meetings, including treatment planning and patient review meetings, ensures that treatment plans are completed in a timely fashion and in keeping with hospital standards, and effective utilization of the Program's core components. The Team Leader is also responsible for: (a) assisting the Program

Director in the provision of program specific training; and (b) direct supervision of treatment team members.

Program Nurse Manager

The Program Nurse Manager is responsible for ensuring that standards of nursing practice and all applicable nursing policies are satisfied within the program and in a manner consistent with the program's core rehabilitation technology. The Program Nurse Manager is also responsible, in coordination with the facility nursing schedulers, for ensuring that nursing personnel are appropriately staffed, and with the correct skill mix, to meet each residential area's minimums and acuity needs. In addition, this individual ensures, in conjunction with the Team Leader and Program Director that nursing staff are effectively integrated into the Program Schedule, and that the interventions provided are in keeping with program expectations. The Program Nurse Manager is also responsible for: (a) providing direct oversight, coaching and modeling of all nursing staff; and (b) attending to all risk management activities, including those involved with daily incidents and injuries, and the program's response to both medical and psychiatric emergencies.

Program Psychiatrist

The Program Psychiatrist ensures that the psychiatric care is provided to all patients on the program. In addition to those standards specific to medical and psychiatric practice, this includes, the psychiatrist is responsible for: (a) Providing clinical direction to treatment team members regarding patient interventions, consistent with the standards of medical and psychiatric practice, and the treatment and rehabilitation approach specific to the Clinical Program; (b) Issuing medical orders for precautions, privileges, passes, admissions, discharges and transfers, consistent with the client's clinical presentation and progress through the Clinical Program.

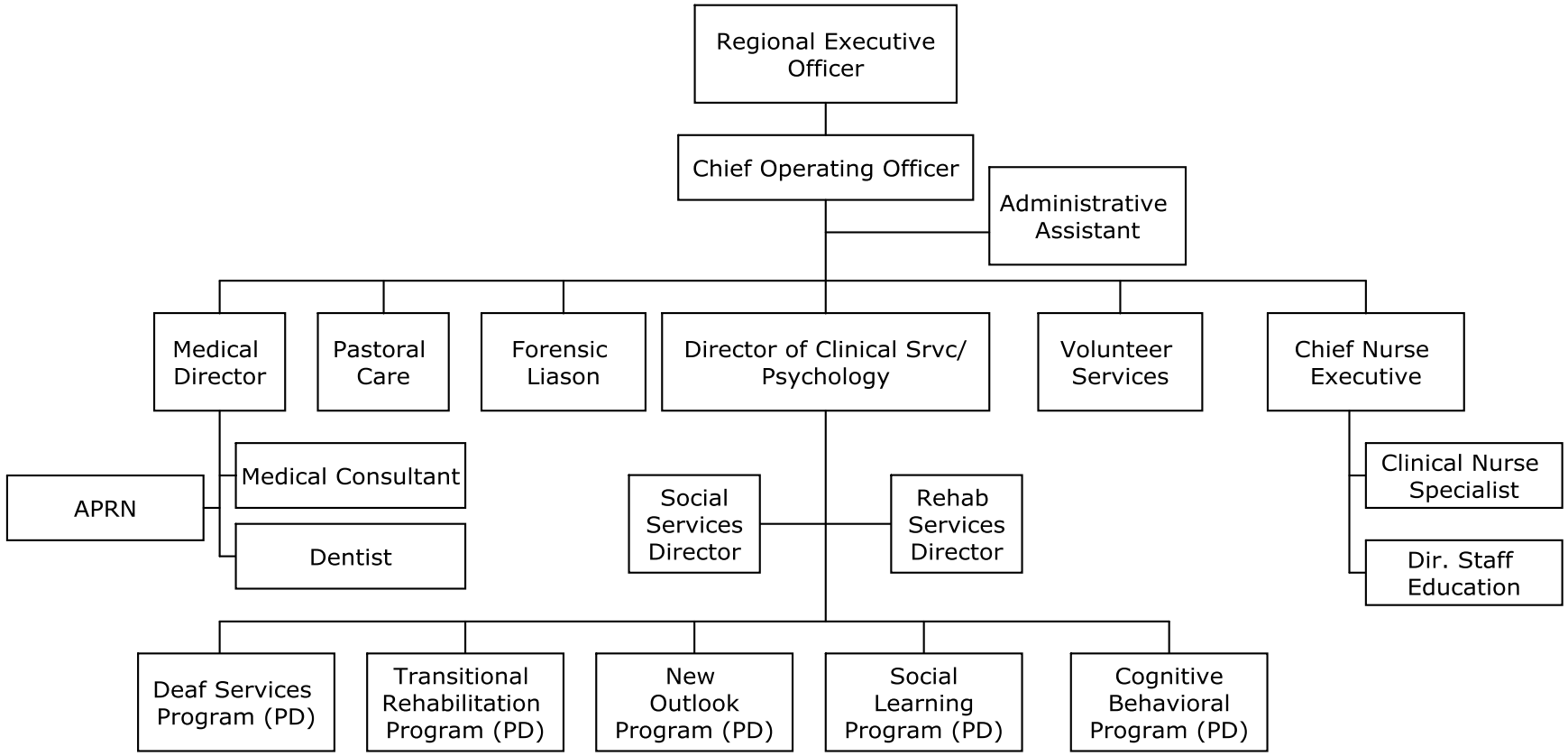
Other Key Leadership Positions

- **Chief Accountant**
- **Hospital Management Assistant**
- **Director of Communications and Fire and Safety**
- **Director of Health Information Management**
- **Director of Dietary Services**
- **Director of Security**
- **Director of Housekeeping**
- **Infection Control Coordinator**
- **Director of Pastoral Services**
- **Director of Maintenance**
- **Director of Purchasing**
- **Director of Pharmacy**
- **Director of the Warehouse**

Tables of Organization

The organizational structure for hospital leadership is contained in the following figure.

Leadership Table of Organization



Program staff are supervised on a matrix model between the discipline and program chains of command, with clinical department heads responsible largely for ensuring standards of practice for the discipline, and program directors responsible for integration of clinical roles for the delivery of the rehabilitation technology. The following is a description of the program and discipline responsibilities under the matrix:

Matrix Responsibilities

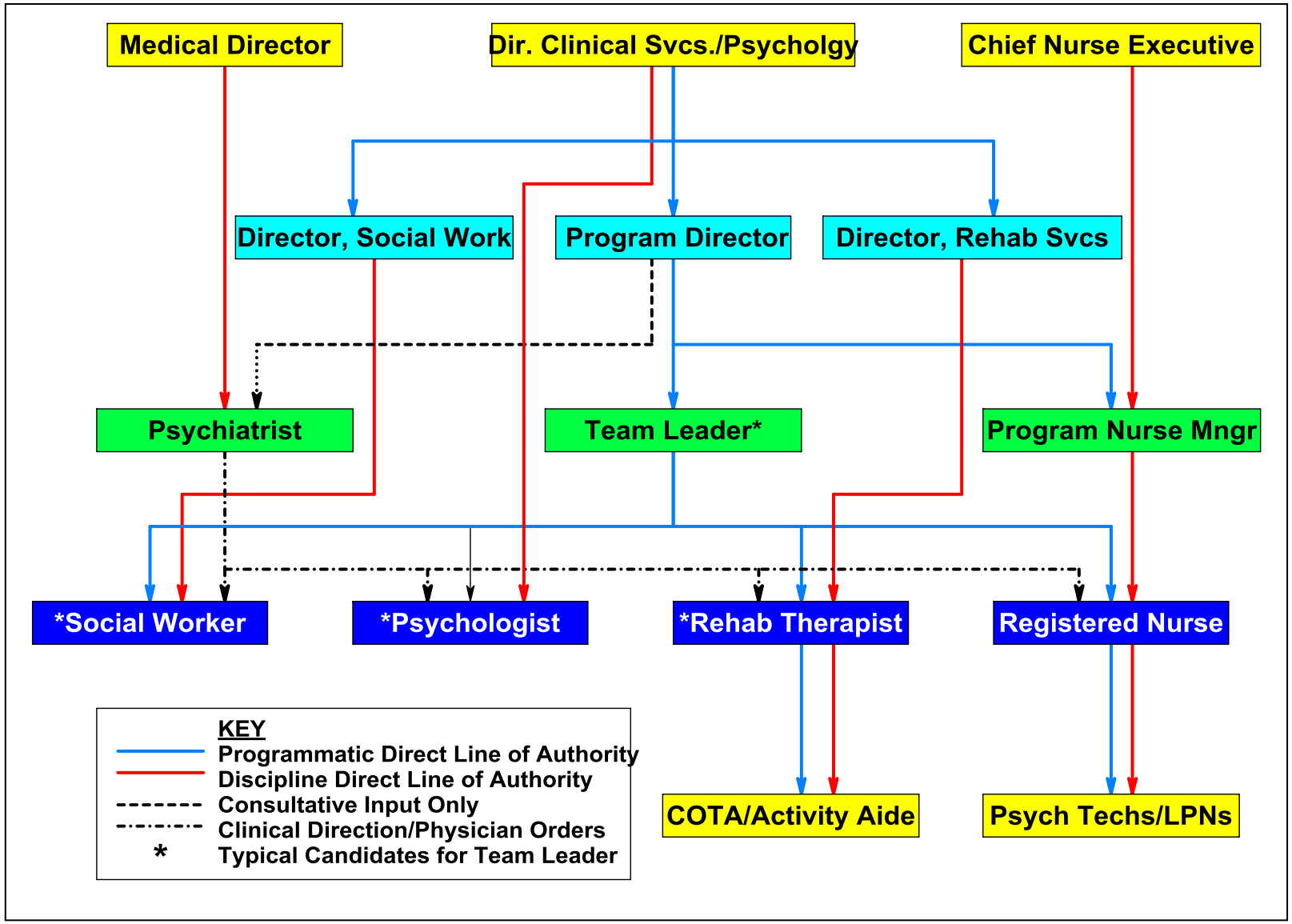
	Programmatic Chain of Command	Discipline Specific Chain of Command
Assessment	Completion of any program-specific assessment methodologies (e.g., HARE, CFRS, etc.), consistent with discipline assigned privileges and consistent with programmatic standards of quality	❖ Privileging for discipline specific assessment and program-specific assessment methodologies ❖ Adherence to discipline specific standards of quality
Treatment Planning	❖ Preparation for Team Meeting ❖ Participation in Treatment Planning Meeting discussion and adherence to assigned meeting roles (e.g., recorder, case management, treatment plan review note, etc.) ❖ Assignment to (a) programmatic services consistent with discipline assigned privileges, and (b) to non-service interventions consistent with generalist programmatic expectations	❖ Privileging for delivery of Services
Treatment Delivery	❖ Development of the Programmatic Schedule, consistent with needs identified across client Treatment Plans and periodic surveys of clients preferences ❖ Delivery of program specific treatment and rehabilitation interventions and services, consistent with assignments made in treatment planning and in accordance with the Programmatic Schedule, and any subsequent adjustments made to either, consistent with discipline assigned privileges ❖ Delivery of program specific treatment and rehabilitation interventions and services, consistent with program specific standards of quality (e.g., DBT delivered in a manner consistent with fidelity to EBP requirements)	❖ Adherence to discipline specific standards of quality in treatment and rehabilitation delivery (e.g., psychotherapy delivered in a manner consistent with discipline specific standards of quality)

Progress Notes	None	❖ Adherence to facility policy regarding frequency of progress notes and completion of all required progress note elements ❖ Adherence to discipline specific standards of quality
Training	❖ Development, scheduling and delivery of any training specific to the delivery of the program, with the provision of notice to the appropriate discipline director(s)	❖ Development scheduling and delivery of any training specific to the discipline, with provision of notice to the appropriate program director(s)
Policy Adherence, Standards of Conduct	❖ Determination and enforcement of policies guiding program specific assessment methodologies, and the delivery of programmatic interventions and services consistent with the delivery of the Programmatic Schedule	❖ Determination and enforcement of policies specific to the discipline standard of practice ❖ Enforcement of all policies established by the facility, all regulation developed by the Department of Mental Health, and any Statutes governing employee practice
Hiring	❖ Determination the skill sets needed for delivery of programmatic services and interventions ❖ Determine the discipline mix needed for delivery of programmatic services and interventions, provided that all relevant CMS and TJC expectations are fulfilled for treatment team composition and delivery of services ❖ Participate in the hiring process, with the option to veto any hire judged incompatible with programmatic needs, provided that this participation does not impede the hiring process <u>Note</u>: Any changes to the staffing plan impacting whole house distribution of staffing resources within the discipline must be coordinated with the discipline chain of command.	❖ Recruitment, interviewing and hiring for the discipline mix and skill sets articulated by the program, and consistent with CMS and TJC expectations for treatment team composition and delivery of services <u>Note</u>: Any changes to the staffing plan impacting programmatic staff must be coordinated with the programmatic chain of command.

Hours of Work and Timeliness and Attendance	❖ Development of the required hours of work for all non-nursing staff ❖ Monitoring for timeliness and attendance of non-nursing and non-medical staff ❖ Approval of time off for all non-nursing and non-medical staff (with the provision of notice to discipline directors to facilitate whole house responsibilities)	❖ Nursing: Development of the required hours of work, consistent with 24/7 oversight responsibilities; (b) Monitoring for timeliness and attendance ❖ Medicine: Development of the required hours of work, consistent with physician coverage responsibilities within the program and across the hospital; (b) Monitoring for timeliness and attendance ❖ Nursing and Medicine: Approval of time off for discipline members, with the provision of notice to program directors to enable necessary adjustments to Programmatic Schedule
Discipline	❖ Discipline attendant to any of the responsibilities articulated above, with the provision of notice to discipline directors. Note: Within the nursing chain of command, should the discipline involve termination, that decision should be made with the concurrence of the CNE.	❖ Discipline attendant to any of the responsibilities articulated above, with the provision of notice to program directors

The following figure describes the matrix on a table of organization:

Matrix Table of Organization



The following describes the matrix relationship between Team Members and Team Leaders in the supervisory chain of command for the ENGAGE process. Note: as used in this paragraph, the term "Team Lead" is generic in nature and reflects individuals in the supervisory relationship, rather than the specific position in the hospital matrix, known as the "Team Leader" which is responsible for leading each individual in the inter-disciplinary treatment team.

SLPRC Matrix Based Model of Supervision for ENGAGE

TEAM MEMBER Job Title	TEAM LEAD Program	TEAM LEAD Discipline	CONTRIBUTOR	TEAM AUTHORITY
PT I, II	RN Senior	RN Senior	Chief Nurse Executive (CNE)	Team Leader Program Nurse Manager (PNM)
LPN/RN	RN Senior	Team Leader	CNE	PNM
RN Senior	Team Leader	PNM		Program Director (PD) CNE
PNM	PD	CNE	Director of Clinical Services (DCS)	COO
Social Worker	Team Leader	Social Services Director		Program Director
Psychologist	Team Leader	Psychology Director		Program Director
Recreational Therapist	Team Leader	Recreational Therapy Director		Program Director
Spec. Ed. Teacher	Team Leader	Rehab Services Director		Program Director
Activity Aides	Central Activity Therapy Director	Rehab Services Director		DCS
Psychiatrist		Medical Director	Program Director	COO
Team Leader	Program Director	Appropriate Discipline Director		DCS
Program Director	DCS			COO

Core Expectations

1. Each TEAM MEMBER will meet with one of their TEAM LEADS at a minimum of once per month to review professional goals, core expectations of the job, and to provide bi-directional feedback between LEAD and MEMBER.
2. The TEAM LEADS for Discipline and for Program coordinate their efforts to avoid confusion and conflict for the TEAM MEMBER, and distribute their monthly ENGAGE meetings in a roughly even manner throughout the year.
3. The CONTRIBUTOR is an individual who has the authority to provide consultative input into the ENGAGE process based on their observation of the TEAM MEMBER's performance as it impacts standards of practice for the Discipline or Program.
4. The TEAM AUTHORITY(ies) are responsible for resolving any confusion or disputes among TEAM MEMBERS and TEAM LEADS.

PROGRAMS

Deaf Services Program

The Deaf Services Program serves Deaf and Hard of Hearing clients who have mental illnesses and require intermediate to long-term inpatient treatment to address emotional, behavioral, and communication challenges. Our staff is trained in the unique culture of the Deaf community and offer a therapeutic environment that is both socially and environmentally designed to meet the specific needs of Deaf and Hard of Hearing clients.

The Deaf Services program must treat clients whose clinical presentations are very diverse, other than being inclusive of hearing loss, with many demonstrating a wide variety of language, emotional and behavioral challenges, many of them severe in nature. This requires a programming approach that is eclectic and generalist in nature, targeting the individual and heterogeneous treatment needs of each client, encompassing a range of therapeutic approaches, including cognitive behavior therapy, illness management and recovery, and behavior therapy. There is a focus on teaching basic and advanced social skills, including coping, conflict resolution, communication, interpersonal, and problem solving. In addition, the staff interpreter conducts a Communication assessment to identify communication strategies that are most effective for use with each client, ensuring that all treatment team members are familiar with a client's preferred modes of communication.

All interventions are informed by the values of Recovery and Psychosocial Rehabilitation, emphasizing client strengths and the empowerment necessary to make informed choices. The emphasis on strengths and skills teaching facilitates engagement in treatment for clients who have likely been marginalized and have had limited opportunities to benefit from treatment.

The Deaf Services Program will emphasize a culturally affirmative approach with most services being offered to the clients as a group. Group work is most effective with deaf peers and a variety of visual methods should be used. When clinically appropriate, other deaf clients at SLPRC who cannot be safely housed with those in Cottage C may participate in services offered to Cottage C clients. Clients will also participate in programming broadly offered to all SLPRC clients, such as the Client Work Program (CWP) and Central Activity Therapy. In addition, when indicated in their treatment plans, clients will have the opportunity to participate in select, specialized groups available in other rehabilitation programs such as Sex Offender Group.

Program Director: Peter Scheers, MS
Location: Cottage C

Cognitive-Behavioral Program

The Cognitive-Behavioral Program (CBP) is a self-contained cognitive behavior program that focuses on individuals who have a high risk of behavior in conflict with the law as a result of a severe personality disorder. Although the majority of the population has a co-morbid serious mental illness, it is often not the focus of treatment and for many of the clients, their mental illness is in partial or complete remission. However, a substantial cohort of the population exhibits behavior that may be secondary to a variety of factors that renders them at risk of violence to females in the other co-ed residential areas of the facility. Programming is structured around principles, techniques, and concepts of TruThought, developed by cognitive-behavioral and offender treatment researchers and providers who were influenced by such nationally recognized individuals as Aaron Beck, Marsha Linehan, Samuel Yochelson, Stanton Samenow, William Pithers, Reid Meloy, and Mary Ann Layden. The methodology involves the application of cognitive behavioral principles to identify errors in thinking and to assist in the modulation of affective states, thereby decreasing vulnerability to antisocial behavior.

Modalities available to clients in CBP include Responsibility Therapy for individuals with Antisocial Personality Disorder. Individuals with sex offense crimes, or a behavioral history of sexually inappropriate behavior participate in cognitive-behavioral sex offender groups. Other treatment groups include anger management and Integrated Dual Disorder treatment. An additional function of Ward E is to provide stabilization of acute psychiatric, behavioral or physical problems that may occur with a client in a cottage setting.

Program Director: Kathryn Thumann, LCSW
Location: Minimum Security Ward E, Cottage A; Campus Security: Cottage 10

New Outlook Program

The New Outlook Program is a based largely on the work of Marsha Linehan and embraces all the core components of Dialectical Behavior Therapy. The clients' most common diagnoses include Borderline Personality Disorder, Schizoaffective Disorder, or Bipolar Affective Disorder, in which the most common clinical features involve significant levels of emotional dysregulation, often culminating in explosive affective displays leading to self harm and/or other directed aggression. Many of the clients have significant intellectual deficits, which results in many of the features of DBT being less focused on cognitive therapy than on emotional regulation skills. Individual therapy and social skills groups for clients, along with case consultation group for staff, are integral

elements of the program. An additional track is provided to female clients who present substantial features of antisocial personality disorder.

Program Director: Blake Schneider, LCSW
Location: Minimum Security: Ward F, Cottage B; Campus Security: Cottage 12

Social Learning Program

The Social Learning Program (SLP) is a self-contained psychosocial rehabilitation program serving clients who are substantially impaired as a result of a severe and persistent mental illness. The program is designed to address a range of client needs. For older individuals or severely regressed clients, and those with persistent medical concerns, Ward H offers individualized, remedial interventions based upon general behavioral principles such as Operant Learning, Associative Learning, Modeling and Direct Instruction. One to one therapy is provided as needed. Traditional Social Learning methods (as formulated by Gordon Paul) are provided in Ward G. This method involves a highly-structured and intensive application of Learning and Behavior Therapy principles. Significant disruptive behaviors, skill deficits and psychiatric symptoms that interfere with and prevent successful community integration are addressed. As clients demonstrate improvement by refraining from problematic behavior and increasing independence, they may be advanced to a Social Learning cottage. The cottages provide an environment in which clients can practice skills and self-control within a format of gradually titrated structure to simulate a community environment.

Program Director: Margaret Shepherd
Location: Minimum Security: Wards G and H; Campus Security: Cottages 6 and 8.

Transitional Rehabilitation Program

The Transitional Rehabilitation Program (TRP) is based on Psychiatric Rehabilitation and the work of William Anthony, and is structured around the evidence based practice of Illness Management & Recovery. The clients are among the highest functioning in the hospital, and are being actively prepared for reintegration into the community in independent or semi-independent living arrangements. The program is structured around recovery and rehabilitation principles and is focused on the development of the skills and resources necessary for clients to fulfill successful roles in the community.

Program Director: Peter Scheers, MS

Location: Campus Security: Cottages 2, & 4; Minimum Security: Cottage D

Rehabilitation Services

The Rehabilitation Services (RS) is a non-residential treatment and service program providing interventions to all residential programs. RS staff provide rehabilitation services in the classroom, cottage, and community settings. There are several components within RS including Central Activity Therapy, and the Client Work Program

Central Activity Therapy provides facility wide services involving recreation, fitness, self-development and leisure skills experiences. Services are provided primarily in the Gymnasium, Fitness Room, and Social Area. (See Ancillary Services)

Client Work Program affords clients opportunities to develop basic work behaviors and vocational skills. Clients interested in participating in a work experience and/or vocational training are referred to the Client Work Program through their Treatment/Rehabilitation Team and are interviewed to determine vocational interests and needs. Based on assessment results and client choice, skills and experience, the client participates in one of three work phases: either a sheltered workshop environment (Phase I), a semi-independent work site on the facility grounds (Phase II), or community-based vocational activities involving either vocational training (e.g., Missouri Division of Vocational Rehabilitation, Supported Employment through the Independence Center) or competitive part-time or full-time employment (Phase III).

It is the objective of the Client Work Program to assist clients in developing the ability to assume higher levels of responsibility and skill, with periods of work extending from 1.5 to 3 hours per day and from 1 to 5 days per week. This is predicated on the belief that meaningful work activity is integral to successful community reintegration and is one of the most powerful factors militating against psychiatric relapse and recurrence of criminal activity.

Program Director: Peter Scheers, MS

CONTINUITY OF CARE

Screening and Admission

Clients are admitted to the facility through the auspices of the Administrative Agents, or upon transfer from other DMH long-term care facilities, or directly through the Courts or the Director of Forensic Services. All clients are screened for appropriateness of admission and program placement by the Chief Operating Officer, with consultation and more in-depth assessment from appropriate program staff when indicated. The screening process is guided by efforts to identify the client's general rehabilitation needs and the facility's ability to provide necessary services and settings, and by the admission criteria contained in each Program Manual. In addition, specific exclusionary criteria with recommendations for disposition are contained in the hospital policy on "Intake Procedures for Adult Psychiatric Services" (Policy SLPRC PC.06.06).

Upon admission, the facility ensures that appropriate linkages are made with the referring agency to facilitate the client's entry. The needs of the client are discussed with the client, his family (this includes person[s] who play a significant role in the client's life who may or may not be legally or biologically related), guardian (if any), and the referring agency. A client and family brochure is provided to each client and to interested family member upon request. The brochure includes information about the nature and goals of each program, visitation hours, and individual rights and responsibilities. The costs of care and service are explained by the Resources Office. If necessary, arrangements are made through the Administrative Agent for dependent care services.

Clients in the Eastern Region who meet criteria for admission are accepted as follows:

1. Circuit Court Criminal Division - Direct Admissions[1]

   Not Guilty by Reason of Mental Disease or Defect

   Clients who are brought to trial and adjudicated Not Guilty by Reason of Mental Disease or Defect (NGRI) are committed to the Department of Mental Health for care and custody. Those NGRI clients who can be safely managed in either a Minimum or Open Campus setting, and who reside in the Catchment Area, are admitted to SLPRC.

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[1] Note: Clients in any of the categories below who have committed Major Offenses (includes (a) Murder in the first or second degree; (b) first degree Assault; (c) first degree Arson; (c) Sexual Assault; (d) Forcible Rape; (e) Forcible Sodomy; (f) Kidnapping; and (g) first degree Robbery) are not admitted to St. Louis Psychiatric Rehabilitation Center. Instead, they are diverted to the Maximum Security Unit of Fulton State Hospital.

2. Transfers from other Department of Mental Health Long-Term Care Facilities.

   a) NGRI Transfers from Fulton State Hospital

      Transfers from Intermediate Security are initiated upon recommendation of the Chief Operating Officer, or designee, of Fulton State Hospital. The COO of Fulton State Hospital sends an information packet for review by the Chief Operating Officer of SLPRC. If concurrence regarding transfer is obtained, or if rejected and the arguments for rejection are reviewed by the Division Director with the decision that the transfer will occur, the transfer shall occur within ten working days of the receipt of a favorable decision.

   b) PIST Transfers from Metropolitan Psychiatric Center

   c) Transfers from other DMH Facilities

      The request for transfer is made by the referring facility after providing information as to how a transfer is in the best interests of the client and his family. Transfers from SMMHC are often considered, given the volume of clients transferred there from Fulton State Hospital, whose original county of residence was in the Eastern Region.

3. Inter-State Compact

   A state participating in the Inter-State Compact Agreement may request transfer of a client through the Missouri Department of Mental Health's, Director of Client Admissions, Discharges, and Transfers, who completes a preliminary screening and accepts or rejects the transfer.

5. Readmission

   a) Revocation or Lapse of either PIST or Conditionally Released NGRI Clients

      The Director of Forensic Services initiates a revocation or lapse of Conditional Release, after determining that a client is not abiding by the Conditions of Release and poses a potential or actual danger to public safety. PIST clients whose behavior in the community demonstrates a need for readmission to inpatient settings will be readmitted with consultation from the community provider.

   b) Other Clients

      The Administrative Agent or Affiliate Provider initiates a request for hospitalization after determining that a departmental client can no longer

be safely maintained in the community with the available support services. Such admissions would require the permission of the Division Director for the Division of Behavioral Health.

Assessment, Diagnosis and Treatment Planning

Basic to the understanding and rehabilitation of the client is an accurate assessment and diagnosis that include consideration of the client's medical, psychiatric, psychological, and social needs. Assessments are conducted by the physician, psychiatrist, nurse, social worker, activity therapist, clinical dietitian and dentist. All but the latter two are completed within 10 days of admission.

The content of these assessments and their specific time lines are prescribed in the Medical Records Handbook. Each is monitored both by the rehabilitation programs and clinical departments for adherence to discipline standards of quality and requirements for timeliness and completeness. There is a continuing effort to ensure that the assessments are grounded in the program's rehabilitation methodology and prioritize those goals and problems most critical to the client's safe and successful reintegration into the community.

The initial Treatment Plan is completed by the psychiatrist upon admission, and discussions with the client, his family, the Administrative Agent or Affiliate Provider, and for readmission of forensic clients, the Forensic Case Monitor, members of the inter-disciplinary team complete intensive assessments. The assessments consist of, but are not limited to, a comprehensive evaluation of the client's physical condition, behavioral patterns, emotional, social, recreational, nutritional, legal, vocational, spiritual and cultural/ethnic needs.

Treatment and rehabilitation planning efforts are to incorporate the input of the client, his family and Administrative Agent, and represent a distillation of the assessments described above. The programs develop problem-focused Individualized Treatment and Rehabilitation Plans (ITRP). Each ITRP is to include measurable, behavioral and verifiable problem/outcome statements, with objectives, assets, interventions, responsible staff, reason for admission, diagnosis and criteria for discharge. Fundamental to the ITRP is the expectation that the client's own goals form the bases of the treatment planning process, structured around his or her expectations of skills and resources needed for where they want to live upon release, the work they would like to perform, and the social group to which he or she wishes to belong. A treatment team member is assigned to assist them in the formulation of their plan as a "Client Advocate" and helps to facilitate the client's discussion when meeting with the treatment team as a whole. This was the culmination of a significant hospital initiate implemented in October of 2015.

A Master Treatment and Rehabilitation Plan is developed by the 10th day of admission. The treatment plan is reviewed within 30 days, and for the first year every 60 days thereafter. After the first year, the review is conducted at least every 90 days. It is expected that all treatment plans will be reviewed and revised as necessary following significant changes in the client's condition, including dramatic changes in mental status, medical condition, and homicidal or suicidal risk. In addition, should such critical incidents as escape, assault, restraint usage, or falls recur within a normal review period, the treatment plan should be subjected to further review.

Transfers to Other Programs and Levels of Care

Transfers among programs are possible when an assessment of the client's overall clinical picture suggests that another program could better meet his treatment and rehabilitation needs. Such transfers are guided by the hospital policy on "Transfer of Clients Between Programs" (Policy SLPRC.06.18) which stipulates how responsibilities for a client's care are shifted from one program to another and the conditions under which a transfer can occur. However, the program realignment that was implemented in October of 2015 has minimized the need for cross-program transfers, as it is the hope that all clients remain within the same program, regardless of security level, and remain with the same treatment team from the point of admission to the point of discharge to facilitate continuity of care and to reduce overall length of stay.

Transfers across security levels within the same treatment program are driven by substantial changes in client acuity, and the client's readiness for preparation for independent or semi-independent community living.

If a client's mental status deteriorates to the point that maintenance in a Minimum Security setting is deemed to pose a risk to other clients, staff or the community at large, a transfer to the Intermediate Security Unit, or if the risk is especially serious, to the Maximum Security Unit of Fulton State Hospital is pursued according to the requirements listed in the Department Operating Regulations and state-wide Forensic Manual.

Discharge and Post-Discharge Planning Process

Clients are discharged when those treatment and rehabilitation needs most critical for reintegration into the community have been achieved to the satisfaction of the Treatment Team, the client, his family, the Chief Operating Officer, the Administrative Agent, and where applicable, the Director of Forensic Services and the courts.

The discharge planning process is begun by the Treatment Team upon the client's admission to the facility, again with involvement from the client, his family and the Administrative Agent responsible for the orchestration of his mental health services. Planning efforts honor the client's discharge goals in the area of housing, socialization, work/education, and leisure, within the constraints imposed by the client's mental illness and public safety concerns. Placement options explored include the client's family, independent community living, or supervised congregate living facilities, all with varying degrees of case management and supported living services, depending on the degree of structure, supervision and follow-up needed for the client's safety and that of the community.

Voluntary by guardian clients may be discharged upon the request of their guardian, if their psychiatric condition does not call for involuntary civil commitment.

However, if the client is NGRI, the discharging Treatment Team is to complete well prior to the actual discharge an application for Conditional or Unconditional Release, stipulating the circumstances under which the client will be released and the degree of supervision provided by the Administrative Agent or Affiliate Provider, family and the Forensic Case Monitor responsible for monitoring the client's compliance with any stipulated conditions. This application is reviewed by an independent body within the facility known as the Forensic Release and Review Committee, comprised at a minimum of the Medical Director, Chief Operating Officer, and a staff psychiatrist (Currently comprised of the required members, plus a psychologist, Assistant General Counsel for DMH, and Director of Clinical Services). If approved, the application is referred to the Chief Operating Officer for authorization. All forensic conditional release requests must obtain the approval of the DMH Director of Forensic Services and an independent psychiatric reviewer from DMH Central Office. Finally, the application is submitted to the appropriate court: If the client committed a dangerous felony (first or second degree murder, arson, first degree assault, forcible rape, forcible sodomy, kidnapping, first degree robbery, or sexual assault), the release must be approved by the court where the crime was originally tried and acquitted. In addition, the prosecuting attorney of the county where the client will live, the prosecutor of the county of original jurisdiction, the prosecutor of the county in which the facility is located, and any victims of the crime must be notified of the application. If committed for a minor offense, the application is filed in the court having probate jurisdiction over the facility, with the prosecuting attorney of the county of original jurisdiction and the prosecutor of the court in which the application is filed notified of the application. All prosecutors have 30 days after filing of the application to object to the release (victims express objection through the prosecutor). If approved -- approval subject to a determination that they pose no significant risk to public safety -- a court order for release is issued by the appropriate judge. If an objection is filed by the prosecuting attorney, a hearing is held in the appropriate court.

Once approval is obtained and discharge is imminent, the circumstances surrounding the placement are clearly documented in the Discharge Summary/Aftercare Plan. These summarize the treatment and rehabilitation received while in the facility and include plans for addressing the client's needs as he moves to the next level of care in the community (including transportation, medical and psychiatric treatment). The Medical Records Handbook stipulates the additional information to be provided to the Administrative Agent to assist in its planning efforts. This culminates in the development of an outpatient Individualized Treatment and Rehabilitation Plan by the Administrative Agent prior to the actual release with involvement from the hospital staff, client, and family.

Placement resources utilized in the discharge process include: (1) private residential services, including group homes, residential care facilities (boarding homes), and independent housing; (2)skilled and intermediate nursing facilities for those clients who present with significant co-morbid medical conditions which would qualify them for nursing home care; and (3) support services, including community support, intensive community support, medication monitoring and administration, psychosocial rehabilitation, partial hospitalization, day treatment and crisis intervention. Each of these is provided under the auspices of the various Administrative Agents, comprised of Administrative Agents responsible for the provision of mental health services in specific service/catchment areas in the Eastern Region, and their Affiliate Providers with whom they have contractual agreements for services.

As a result of the Inpatient Redesign initiative, SLPRC has additional resources for community reintegration to support individuals who have historically not been successful in existing community placements. These resources involve a tenfold increase in the dollars available for services and supports and include the following placement and treatment options: (1) Clustered Apartments: apartment settings with on-site services and supports for individuals who are clinically appropriate for a semi-independent living environment and who do best clinically when not required to immediate living space with other individuals; (b) Intensive Residential Treatment Services (IRTS) Settings: congregate living settings of 5 to 16 beds for individuals who require more intensive supervision than in a Clustered Apartment, with direct access to mental health professionals who can provide a combination of onsite and community based services; and (c) Psychiatric Independent Support Living (PISL) Settings: congregate living settings of 2 to 5 beds for individuals who require the most intensive level of supervision and for whom the majority of professionally delivered services are best provided on site.

Administrative Agents	**Affiliate Providers**
BJC Behavioral Health	Independence Center
COMTREA	Places for People

COMPASS Mental Health Center (dba Crider Center)	ADAPT of Missouri
Hopewell Mental Health Center	Preferred Family Healthcare
Mark Twain Behavioral Health	Comprehensive Health Systems
East Central Missouri Behavioral Health (dba Arthur Center)	

The social worker or Case Manager assures proper linkage with community resources after discharge and coordinates any needed transitional services from inpatient staff. In addition, the social worker participates as needed in any post-discharge planning by the Administrative Agents.

ANCILLARY SERVICES

The hospital maintains a number of basic services above and beyond those available from the Rehabilitation Programs that address the social, emotional, physical, vocational and spiritual needs of clients.

Central Activity Therapy

Client Library

The Client Library provides a variety of recreational and reference materials, including information on mental illness and materials for Basic Survival Literacy, GED training, and supervised (approved) Internet access. Additional services include a bookmobile which distributes books to clients throughout the hospital, a computer resource room and current events programs.

Social Recreation Area

The Central Activity Therapy staff is responsible for coordination of various large and small group and leisure activities. Services for special groups are provided upon request. This area is also used as a client lounge and contains the hospital canteen and various recreational equipment including: pool table, video games, and large screen TV for special events.

Gymnasium and Fitness Center

Indoor and outdoor recreation areas are provided in the hospital complex for client use during rehabilitation and leisure times. These include a fully equipped Fitness Center, a gymnasium and an outdoor court yard where various recreational activities are held. These areas are scheduled through

Central Activity Therapy for regular and/or special use. When not scheduled, outdoor areas, these areas are available for independent use by clients with equipment checked out through the Central Activity staff.

Barber and Beauty Shop

The Barber and Beauty Shop provides a full line of hair care to all clients. Services are provided both on-ward and by appointment in the shop. A licensed cosmetologist offers consultations for clients with scalp problems and to discuss various ways to care for their hair.

Pastoral Services

The department provides: (a) liturgical services from a variety of faith experiences arranged on a contract basis; (b) coordination of religious volunteers; (c) pastoral counseling; (d) spiritual assessments and consultation with the Rehabilitation Team on the relationship between mental illness and spirituality; (e) involvement of the client's faith community in discharge planning efforts; and (f) consultation on Advanced Directives.

B.R.I.D.G.E.S

Building Recovery of Individual Dreams and Goals through Education and Support (BRIDGES) is a program of classes implemented at SLPRC conducted by and for individuals with mental illnesses. Clients enroll in 5 or 10 week courses that explore diagnoses, treatments, medications communication and other aspects of recovery. Once they have completed these courses, clients may be considered for teaching positions within BRIDGES, and if hired, will act as teachers for future classes both within SLPRC and in the community upon discharge.

Dietary

Dietary Services are provided for all clients. Registered dietitians complete initial and annual Nutritional Assessments. When indicated, risk assessments for choking are conducted upon admission and reviewed annually. Dietary personnel are responsible for preparing and serving meals in accordance with specific diet orders. In addition, registered dietitians participate in the interdisciplinary rehabilitation teams and provide specific rehabilitation services in each of the rehabilitation programs. Finally, dietary work sites are an integral part of the Client Work Program.

SLPRC Medical/Dental Clinic

Dental Services

General dental services provide Initial/Annual Dental Assessments and ongoing follow-up care/treatment for all SLPRC clients. Dental services are provided by a dentist and a dental hygienist. Dental clinic hours are 8:00 am to 4:30 PM, Monday through Friday. Appointments are scheduled through the medical/dental clinic secretary at ext. 5827. Urgent appointments are available during and after clinic hours through arrangements made with the dentist.

General Medical Services

General medical services are provided by general physicians/APRNs on staff. The medical providers are responsible for covering general medical issues for all clients and function out of a centralized medical clinic. If a client is not able to come to the clinic for general medical services, arrangements are made for the client to be seen by the general physician on the client's ward or in their cottage. The general physician is responsible for the general medical care of the clients twenty-four hours/day - seven days/week. In house care is provided Monday through Friday 6:30 am - 4:00 PM, with after-hours coverage through the phone/pager system. In the event of a medical emergency, clients are transferred for evaluation/treatment to a general medical hospital through the EMS 911 system.

The medical providers complete an Initial/Annual Review of Systems and Physical Examinations, and provide routine/ongoing medical evaluation and care/treatment to all clients at SLPRC. All specialty care is provided by outside medical hospitals/clinics.

In addition, the following specialty clinic services are available on a contract basis at the following times:

Clinic	Hours		
Optical	10:30 am	-	11:30 am 2nd and 4th Tues.
Optometry	08:30 am	-	09:30 am 2nd and 4th Tues.

The above clinics are held at St. Louis Psychiatric Rehabilitation Center (SLPRC). Clients are referred by their psychiatrist/general physician. Appointments are made by calling the medical/dental clinic secretary at ext. 5827

EKG Services

EKG services are performed at SLPRC and sent out for interpretation by a cardiologist. A physician order is required.

Admissions After Hours

Any person presenting for admission to SLPRC after 4:30 pm, on weekends or holidays are evaluated for medical and psychiatric stability by the nursing supervisor in CNO. As SLPRC is a psychiatric rehabilitation facility, SLPRC does not have an emergency room and does not admit acute clients. If an individual is medically unstable, EMS 911 is called and an ambulance requested for transport to a general medical hospital, while immediate aid is rendered, as would occur if a facility client became medically unstable. If psychiatrically unstable, the individual will be referred to other acute psychiatric care facilities in the Eastern Region.

For individuals in need of revocation of conditional release or readmission due to failed placement from SLPRC and unsuccessful attempts at stabilization in an acute setting, all efforts will be made to admit them during regular business hours. If this is not possible, the admission will be completed by an Admissions Team consisting of the physician on call, a registered nurse, a psychiatric aide, and a security officer. If the client is medically unstable, the physician will admit the client and transfer the client to a medical hospital emergency room for medical evaluation and care.

EEG Services

SLPRC clients are sent to local hospitals, primarily to St. Alexius Hospital or BJC Hospital, and accompanied by SLPRC staff when in need of this service.

Radiology/X-Ray Services

SLPRC clients are sent to local hospitals, primarily to St. Alexius Hospital or BJC Hospital, and accompanied by SLPRC staff when in need of these services.

Pharmacy Services

Pharmacy services for DMH psychiatric facilities in the Eastern Region through are provided through a contract with Pharmacy Systems, Inc. SLPRC “on site” pharmacy hours of operation are 8:00 am to 4:30 pm, Monday through Friday. In addition, a pharmacist is on call during all hours

that the pharmacy is not open. After regular hours, the emergency night cabinet can be used by the nursing supervisor to obtain medication ordered by a physician. The hospital pharmacy meets all the routine medication needs of clients through supplies in stock. Should a medication be required that is not stocked, the pharmacy will make arrangements for it through a local pharmacy. Medications are ordered on the Physician's Orders sheet for in-clients, and on the hospital prescription pads for clients on pass/trial release.

MedLab

MedLab provides a phlebotomist from 6:00 am – 10:30 pm.

Emergency and Urgent Medical/Surgical Care

Clients requiring urgent, emergency, or admission for medical or surgical care/services are sent to St. Alexius Hospital unless another hospital has been requested because of insurance coverage or VA benefits, they are on diversion, a specialty service needed is at another hospital or they have a history of going to a particular hospital for ongoing treatment. A doctor's order is required. A completed consultation form plus other required medical record information (Blue Packet) accompanies the client, who is accompanied to St. Alexius Hospital by escort aides (8:00 am to 4:30 pm), psychiatric aides (4:30 pm to 8:00 am), through the 911 system via ambulance. The extremely rare client who has private insurance has the opportunity to choose where their specialty medical and surgical care will be provided based on their insurance coverage. Veteran's specialty medical and surgical care is provided through the VA hospital.

Speech and Language & Physical Therapy

St. Louis Hearing and Speech provide speech services while Physical Therapy services are provided by Washington University/BJC[2]. A physician's order is required. The appointments are made by the secretary in the Medical Clinic. A completed consultation form accompanies the client, who is taken by SLPRC escort aide staff (8:00 am to 4:30 pm) and transported by SLPRC motor pool.

Services for the Deaf or Hard of Hearing

Audiological Evaluations

[2] The hospital is exploring the potential to have PT services provided through a contract with PSI, which is not yet in place.

BJC Hospital provides hearing and speech evaluation and treatment for clients as required. The physician writes the order for the hearing evaluation and fills out the consultation form. The appointment is made by the secretary in the medical clinic. The client is escorted by SLPRC escort aide staff and transported by SLPRC Motor Pool.

Interpretive Services

Interpretive services are provided by a staff interpreter and/or through contracts with Deaf Way Interpreting Services and Deaf Inter-Link to facilitate communication exchange to and from the deaf and hearing impaired clients.

St. Louis Board of Education

Adult clients admitted to the hospital between the ages 17 years, 9 months and 21 years, who have not completed high school and who desire to do so, are entitled to educational services. The hospital has a teacher on staff that interviews the clients regarding their educational desires and provides educational services to SLPRC clients. When a client requests to attend school, and has received Special Education Services in the past, facility staff notifies the facility's Educational Coordinator, who contacts the Board of Education to arrange for service; current Individualized Education Plan.

STAFFING PLAN

The Staffing Plan is established at the beginning of the fiscal year and is subject to periodic reviews and adjustments throughout the Fiscal Year. The composition and recommendations for changes are a collaborative effort between the Chief Operating Officer, the Program Directors, the Chief Nurse Executive, the Director of Human Resources, with participation from select Discipline Directors as appropriate. Final approval is given by the Executive Committee and the Appointing Authority. The Plan is reviewed regularly by members of the Executive Committee to consider additions, deletions, and alterations.

The Staffing Plan shall be in keeping with Program objectives and components. The Plan shall take into account the workload for each discipline and shall take into consideration:

1. Type of client;
2. Psychiatric symptomatology;
3. Level of functioning;

4. Safety needs;
5. Number of clients in Program; and
6. Client acuity level.

AVAILABILITY OF MANUALS

The St. Louis Psychiatric Rehabilitation Center Plan for Professional Services, Program Manuals, Clinical Department Manuals are available to all employees via copies in offices of the Program Directors and the Discipline Directors, and on the hospital intranet. Also available on the intranet are the Regional and facility Policies and Procedures, and the Departmental Operating Regulations.

EVALUATION

The Plan for Professional Services is reviewed every year and updated based on evaluation activities and major changes in policies or system changes. The review is conducted by the Executive Committee and submitted to the Chief Operating Officer and the Regional Executive Officer for approval.

Evaluation of client outcomes results in modification of the rehabilitation programs, with particular attention to those specific program components or structures for which change is indicated. The entire system is dynamic and responsive to the needs of the client population.

Evaluation of client outcomes occurs at four levels: the client, the program, the facility, and the state level. At the client level, clinical staff evaluates individual client outcomes as part of the ITP process using various data sources. To assist with this process, the Quality Management Department provides clinical staff with a variety of client outcome data upon request. Evaluation also occurs at the program level. Third, evaluation also occurs with facility-wide information. Outcome data collected as performance measures of activities in SLPRC's Strategic Plan are aggregated for program and facility evaluation. In addition, the Quality Management Department collects outcome data on discharged clients and obtains feedback for performance improvement from community agencies that work with our clients upon discharge. Finally, evaluation of client outcome occurs at the state level. The statewide Psychosocial Rehabilitation Committee used statewide data to assist with the selection of the major psychosocial rehabilitation programs and treatment modalities. In addition, the Quality Management Directors from the four long-term inpatient facilities conduct

an annual survey of all inpatients which includes comparative descriptive and outcome data. Client outcome data from all four levels have been used for program improvement and offer opportunities for ongoing improvement.

The Plan for Professional Services of the St. Louis Psychiatric Rehabilitation Center of the Division of Comprehensive Psychiatric Services of the Missouri Department of Mental Health shall become effective when signed and approved by the members of its Governing Body. This Plan shall be reviewed at least every year and may be revised at the discretion of the Governing Body.

_____ _____

SLPRC Chief Operating Officer Date

_____ _____

Regional Executive Officer Date

_____ _____

Director of Psychiatric Facilities Date

Appendix 1: STRATEGIC PLAN Close out CY13 – CY17

Issue Statement #1: "Learn how to learn" to motivate and engage employees and continue to be on the leading edge of excellence

Objectives	Strategies	Responsible Parties	Anticipated Outcomes
1. Develop a systematic approach to learning that will take employees from an awareness level to competence and promote sustaining new skills.	1. Develop consultation relationships with MIMH, and potentially other universities 2. Use Coaching to Competence training approach (didactic training, supplemented by supervised practice until competence is demonstrated) 3. Increase training of para-professionals and support staff using Mental Health First Aide 4. Increase presence of supervisors in direct care areas for real-time coaching/feedback 5. Develop Welcome Wagon to facilitate assimilation of new employees into the organization and its culture	1. Felix Vincenz 2. Department Heads and Staff Development 3. Department of Staff Education, Nurse Educator, Support Side Department Heads 4. Lisa Ellis, Christian Fox 5. Employee Relations and Recognition Committee	Staff will develop competencies in the following EBPs. 1. Integrated Dual Diagnosis Treatment 2. Motivational Interviewing 3. Trauma Informed Care 4. Validation 5. Mental Health First Aid (support side staff, para-professionals)

- Issue 1, Objective 1, Strategy #1 & 2: SLPRC has maintained an active relationship with MIMH, Case Western University in support of the IDDT initiative, and with student training, practicum, internship programs for psychology, social work, nursing, and rehab services. In the process, we have affiliated with the University of Missouri-St. Louis, St. Louis University, Washington University, Southern Illinois University at Edwardsville, Wright Institute, Missouri Baptist Spalding University, Maryville University, and Eden Seminary. In addition, we have supported psychiatry rotations for the Kirksville College of Osteopathic Medicine.
- Issue 1, Strategies 1 & 2, Outcomes 1 & 2: (a) IDDT: The IDDT Learning Community has developed a substance use assessment that has been fully implemented. The Learning Community continues to meet with the community expert who provided additional training in 2016 to increase our knowledge of Motivational Interviewing. At this point IDDT services are offered within each Treatment Program, and DRA continues to be offered facility wide.; (b) Trauma Informed Care: ASAP is fully operational for individual employees, and an additional cohort of volunteers has been obtained to fully staff our ASAP responders, with volunteer training completed. A Trauma Informed Care presentation by our Peer Specialist is fully incorporated in New Employee Orientation. Alive and Well St. Louis is providing training on trauma and toxic stress, and developing Trainers within SLPRC, for use with all employees. The Trauma Informed Steering Committee has been developed and is identifying how to proceed with our hospital self-assessment to enhance Trauma Informed Care for both clients and staff.

Objectives	Strategies	Responsible Parties	Anticipated Outcomes
• Issue 1, Objective 1, Strategy 3, Outcome 5: Director of Staff Education continues to use MHFA as an integral element of basic/advanced psychiatric training classes. To date, trainees have included: (a) 140 new Psychiatric Technicians (PTs); (b) 104 existing PTs; and 119 support side employees. This constitutes a total of 405 employees over the course of the prior three calendar years, an increase of 41 employees (33 PTs and 8 support side staff) trained since the prior strategic plan report. • Issue 1, Objective 1, Strategy 4: (a) Team Leader are either officed on wards or in the main hospital building to facilitate interaction with staff and clients. All positions are filled save one in TRP. Team Leaders, Program Nurse Managers, and RNs are the focus of funding for attendance at Leadership/Management training, with the expectation that all Team Leaders will complete the Basic Supervision training within the next 6 months; (b) Nurse Leadership Council was recently reinstituted under the leadership of Jim Hanson, and is providing a forum for LPNs, RNs, and Senior RNs to shape nursing practice and policy, and enhance the role of professional nurses as leaders of the nursing staff in their residential areas, enabling more direct involvement of Program Nurse Managers to act as direct coaches of nursing practice within their programs; (c) Program Nurse Managers and CNE fully implementing Excellence Algorithm and have an increased focus on real-time coaching, and on standardized inservice training for PTs and professional nurses. • Issue 1, Objective 1, Strategy 5: Already completed			
2. Enhance Program Based Training	1. Develop intro/overview for support side staff, potentially on the intranet 2 Create Mission Statement for each program 3. Develop timely schedule for program based training for 2 – 3 hour awareness level training for all new hires, with 2-4 day utilization training provided to all program hires, with opportunities for periodic refreshers and more targeted training. 4. Disciplines explain the role of their discipline to other clinicians - DISCONTINUED 5. Develop competence in Illness Management & Recovery for TRP employees and expend it to employee of DSP, CPB, and NOP	1, 2, 3. Program Director, Team Leaders, Department Heads 4. Department Heads 5. Peter Scheersa 6. Margaret Shepherd	• Program staff will be more effective at delivery of program technology. • Increased fidelity to evidenced based practice

Objectives	Strategies	Responsible Parties	Anticipated Outcomes
	6. Implement Social Learning on Ward H 7. Expand competence in TruThought for CBP employees	7. Lisa Ellis, Kathryn Thumann	
• Issue 1, Objective 2, Strategy 1: Already completed. • Issue 1, Objective 2, Strategy 2: Already Completed • Issue 1, Objective 2, Strategy 3: Already Completed. Additional program based training was offered in the 4th quarter of CY15, and the 1st quarter of CY16 for those employees whose program was reassigned as a result of the Program Realignment that took place in October of 2015. This included DSP, CBP, NOP, and SLP. • Issue 1, Objective 2, Strategy 5: Completed training for TRP employees, and DSP is using IM&R in conjunction with BJC-BH therapist to its clients. IM&R materials have been shared with and adopted by CBP, with plans to expand to NOP being discussed for the balance of the current calendar year. • Issue 1, Objective 2, Strategy #6: Complete. (a) Teleform now fully operational, and the new CFRS program was installed, with all components of SLP fully introduced to clients and staff on Ward H; (b) New Program Director for SLP, Margaret Shepherd, was hired, and is exploring options with SLP leadership group for ongoing SLP learning and education opportunities; (c) Enhanced integration of the program is awaiting the return of Ward H to the SLPRC campus following the flooring installation. • Issue 1 Objective 2, Strategy 7: A contract has been proposed to TruThought for training at SLPRC, in either fall or winter of CY17, with CSOW funds set aside to training a minimum of 25 individuals (15 from within the program, and 10 from other DBH facilities and community providers.			
3. Enhance cultural competence	1. Implement Cultural Competence Plan for Racial Equity and Learning Exchange (see also Objective #6) 2. Arrange Diversity training through HR with Cornell Dillard/ Mo Dept of Labor 3. All staff within deaf services will develop basic familiarity with ASL. 4. ~~Coordinate with STL Community College for satellite campus on the grounds of SLPRC to focus on ongoing ASL training. Develop funding~~	1. Felix Vincenz, Aaron Atkins 2. Michael McFarlane 3. Peter Scheers 4. ~~Felix Vincenz~~	Increased cultural competence and sensitivity when treating individuals outside the majority culture

Objectives	Strategies	Responsible Parties	Anticipated Outcomes
	~~option from DBH Central Office specific to ASL instruction.~~ 5. SLPRC will fund options for ongoing DSP training through the CSOW and any additional funding available from Central Office. 6. Spirituality assessments to assist teams with the interface between mental illness and spirituality 7. Basic instruction on religious diversity and tolerance 8. Basic instruction on LGBTQ issues.	5. Peter Scheers 6. Karen Pitt 7, 8 Aaron Atkins	

- Issue 1, Obj. 3, Strategy 1: CCC provided multiple training opportunities in April June and July 2016 in consultation with an independent facilitator, completing Phase I of racial awareness training. Phase II, outlining specific action items, organizational goals and deliverables, was initiated in July 2016 and completed in September 2016. Phase III objectives have been identified and reviewed by the Executive Committee and the facilitator, with implementation proceeding. The 10-day Phase III training is expected to begin either in the Fall or Winter of 2017, and will be completed no later than June 30, 2018.
- Issue 1, Obj. 3, Strategy 2: Already completed.
- Issue 1, Obj. 3, Strategy 3: Completed and ongoing as new Deaf Services Program staff are hired, and additional ASL classes scheduled.
- Issue 1, Obj. 3, Strategy 4: Discontinued.
- Issue 1, Obj. 3, Strategy 5: Added. Completed DBT and CBP training.
- Issue 1, Obj. 3, Strategy 6: Already completed.
- Issue 1, Obj, 3, Strategy 7: Cultural Competence Council will begin discussion of specific needs regarding religious diversity, tolerance, and inclusion. Partnership with community resources will be a part of the process, and further discussion is expected during the next Strategic Planning Session.
- Issue 1, Obj. 3, Strategy 8: (a) At the invitation of the Cultural Competence Council, PROMO provided two days of training to staff and clients, with a debriefing to follow along with plans for ongoing contact and support in the years to come; (b) the First Gay Pride event was held, including a LGBTQ+ terminology quiz, popular among our clients, and engendering an open discussion

Objectives	Strategies	Responsible Parties	Anticipated Outcomes
regarding various LGBTQ+ topics; (c) Policy revisions were expanded to include a broader range of protections for various groups.			
4. Leadership Development/Succession Planning	1. Create on site learning opportunities specific to PT and LPN employee to facilitate career progression both within nursing and outside of it. 2. Provide a career path specific to RNs, BSN, MSN as core leadership and recruitment retention initiative 3. PT2/Mentor Program: Ensure that all existing mentors receive mentorship training and all new hires as a condition of passing probation, with bi-monthly access to a learning community 4. Continue involvement in department's Leadership Succession Training	1. Aaron Atkins, Christian Fox 2. Christian Fox 3. Gwen Boyd/Christian Fox 4. Felix Vincenz	1, 2, 3. Provide a career path to existing employees at both the professional and para-professional level to encourage movement into leadership positions at the mentor, supervisory, middle management and executive level
• Issue 1, Objective 4, Strategy 1: Completed and ongoing - (a) Additional Tuition Reimbursement and Stipend funding have been made available through CSOW, E&E and Personnel Service Funding; (b) Additional scholarship funding obtained from the Missouri Hospital Association for 2 other employees. Currently, 2 such employees are being supported; (c) Mental Health Instructor positions have been established and filled from within PT2 ranks within the Department of Education; (d) PTs are being invited to participate in nursing and meetings weekly, and in program specific meetings, and the PT 2s are in the process of developing an every other month learning community to deepen their own learning in mentoring skills and to promote opportunities for further career progression opportunities. • Issue 1, Objective 4, Strategies 1 and 2: This has been embedded in the Cultural Competence Council's RELE Phase III initiative; (b) several LPNs and RNs are receiving tuition reimbursement specific to completion of more advanced degrees, and have expressed interests in remaining connected to the facility upon completion, with several BSN nurses working on their MSN or DNP, and one working on a doctoral degree. • Issue 1, Objective 4 Strategy 3: Reinitiated – (a) Completed the addition of 5 PT2 positions to ensure that 27 PT2s (AKA mentors) are available throughout the hospital (1/ward/shift and 1 for every 2 cottages/shift); (b) All PT IIs identified in December of 2016, have since received the mentorship training, with 8 new PTIIs identified for the next round of training; (c) Learning Community will be also offered			

Objectives	Strategies	Responsible Parties	Anticipated Outcomes
every 2 months to all PT2s, utilizing software support (Captivate) and CNA coursework, after surveying the learning interests of the PTIIs via questionnaire. • Issue 1, Objective 4, Strategy 4: SLPRC sent 2 candidates to the Department's reinitiated Leadership Training.			
5. Promote close working relationship with local universities	1. Each clinician in psychology, social work and rehab services will serve as a clinical instructor for clerkships, practica, internship, and/or fellowships 2. Nursing will continue to provide clinical training opportunities to BSN candidates, with key nursing executives serving as clinical and academic instructors in the BSN programs	1. Lisa Ellis, Jim Mitchell, Peter Scheers 2. Christian Fox	Strong academic relationships will facilitate: 1. Research opportunities, 2. Movement of science to practice 3. Continued learning and refinement of clinical skills among existing staff at SLPRC 4. Recruitment and retention of clinical professionals
6. Enhance our overall culture as a facility, with a greater emphasis on the potential for growth and progress.	1. Establish preceptor pilot program for new RNs on Ward E. 2. Adopt Excellence Algorithm as the tool for promoting a culture of coaching and consoling, rather than corrective action 3. Ensure that PT2s are broadly available to all PT1s for mentoring, with PT2s explicitly trained to mentor new employees in lockstep with the Basic and Advanced Psychiatric Technician training offered by the Department of Education. 4. Develop and implement Phase	1. Christian Fox 2. Felix Vincenz 3. Christian Fox Gwen Boyd 4. Felix Vincenz	1. Junior RNs will be mentored to competence as Senior RNs, with a concomitant reduction in RN turnover 2, 3, & 4. Improvement in employee satisfaction, and improved overall employee performance with reduction in PT attrition

Objectives	Strategies	Responsible Parties	Anticipated Outcomes
	3 of our Racial Equity and Learning Exchange (RELE), with an emphasis on Employee Learning, Career Progression, and Self-Care	Aaron Atkins	

- Issue 1, Objective 5, Strategy 1: CY16 - (a) Social Work: 7% of social work staff have had students, providing a total of 131 student training days (through 2 quarters). Additional students are lined up for the 3rd quarter, so numbers should go up; (b) Rehab Services: 10% of Rehab Services staff (the Hospital Librarian) have had students, providing a total of 87 training days (through 2 quarters); (c) Psychology: 44% of the psychology staff have had students, providing a total of 837 training days (through 2 quarters). In addition, SLPRC is an active participant in the psychology internship consortium, supporting advanced doctoral training in psychology, and graduate training in a clerkship set up with UMSL; (d) Occupational Therapist Assistants are obtaining additional training through Rehab Services (about 5 to 7 a quarter).
- Issue 1, Objective 5, Strategy 2: Nursing clinical from SLU and UMSL are ongoing.
- Issue 1, Objective 6, Strategy 1: Preceptorship training pilot has been concluded and recommendations are in place for expansion beyond Ward F, with 1 RN and LPN to attend September workshops. A proposal is being made to the Regional Executive Officer to expand the mentorship program to other wards.
- Issue 1, Objective 6, Strategy 2: The Excellence Algorithm was developed by the COO, and rolled out after training with hospital leadership, management and supervisory staff in April of 2017. Additional training is being offered to the PTIIs and the Nurse Leadership Council, and program leadership is to introduce the Algorithm within program based training.
- Issue 1, Objective 6, Strategy 3: All PTIs are scheduled during Basic and Advanced Psych Tech training to be mentored during a clinical rotation by a PTII having expertise with the material covered in classroom instruction.
- Issue 1, Objective 6, Strategy 4: Phases 1 and 2 of the RELE initiative have been completed, and a Racial Equity plan was developed for implementation in partnership between facility leadership and Phase 2 participants. The plan is intended to enhance Racial Equity for our African American workforce, and lay the groundwork for future equity efforts among all cultural groups, and will focus initially upon: (a) Employee Education; (b) Career Progression; (c) Use of Data; (d) Communication; and (e) Leadership. The implementation is being led by the Cultural Competence Council and the RELE Phase III team.

Culture of Safety

Issue Statement #2: Create a safe, secure environment for clients and staff and maintain public safety

1. Address annually a key safety issue via the ~~CQI~~ Robust Process Improvement process	1. Reduce treatment failures by effectively addressing antecedents and triggers to aggression through interventions identified by a CQI team on the Team	1. Blake Schneider	• Reductions of restraint usage, instances of aggression

Objectives	Strategies	Responsible Parties	Anticipated Outcomes
	Support/All Available Help process 2. Incorporate suicide assessment and train staff 3. CQI on 1:1/Close Observations	2. Terra Buzzanga 3. Terra Buzzanga, Manisha Lele, Davinder Hayreh	• Adoption of standard of practice in suicide and special precautions
• Issue 2, Objective 1, Strategy 1: (a) Team Support drills specific to each program to ensure program and team-specific competence in the adherence to the Team Support process have been developed during the past calendar year, and are ongoing on a quarterly basis; (b) Episodes of restraint and restraint hours continued to decline overall, with gains most noticeable in NOP and Ward H; (c) SLPRC remains one of the premier facilities within DMH due to its low level of both client and staff injuries. • Issue 2, Objective 1, Strategy 2: Already completed • Issue 2, Objective 1, Strategy 3: Already completed.			
2. Improve medication administration	1. Implement eMAR, BCPOC, and CPOE, with additional enhancements 2. Implement double checks on controlled medications	1. Robert Schmitt, Christian Fox, Davinder Hayreh 2. Robert Schmitt	• Reductions of medication errors and adverse drug reactions • Improved recruitment and retention of RNs
• Issue 2, Obj. 2, Strategy 1: Completed - SLPRC has fully implemented both eMAR and CPOE, and has added additional functionality, including vitals and protocols for pain management and order sets for non-medication interventions. • Issue 2, Objective 2, Strategy 2: Already Completed			
3. Improve hand off and communication across shifts and between programs.	Development of universal report form	Christian Fox	Improve continuity of care and knowledge of client whereabouts and condition
• Issue 2, Objective 3: Interim form in use. Design requirements for new sharepoint tool has been developed in partnership with sister facilities and ITSD. Implementation remains pending once development resources are approved and allocated by the DMH/ITSD Information Technology Advisory Committee (ITAC). Discussions are ongoing between CNE and Medical Director regarding some enhancements, including options to track behaviors over a week's time as opposed to 24 hours.			
4. Improve infection prevention and overall client health.	1. Improve staff and client compliance with Flu Vaccine 2. Improve hand-washing and universal compliance. 3. Improve incorporation of medical conditions on the treatment plan. 4. Implement Client Wellness	1,2 Infection Control Committee 3. Davinder Hayreh 4. Client Wellness Committee	• Mitigate known infection control risks to staff and clients • Increased availability and awareness of client wellness activities

Objectives	Strategies	Responsible Parties	Anticipated Outcomes
	Committee and explore various initiatives for client wellness activities.		
• Issue 2, Objective 4, Strategy 1: Completed and recurring, with client vaccination rates of 80%, with goal of increase to 85% in 2017, by engaging staff in "Flu Shot competition" • Issue 2, Objective 4, Strategies 2 and 3: (a) Developed antimicrobial policy with Pharmacy and Medical Director for implementation in January of 2017, in cooperation with Pharmacy and Therapeutics Committee, to better identify susceptibility patterns of infection and antibiotic use: (b) New handwashing protocol developed to comply with NPSG 07.01.01 and World Health Organization/CDC guidelines, with new cadre of observers selected for more rigorous reviews, observing 10%. of employee population each month, with immediate education in the event of breaches of hand hygiene expectations; although compliance scores have decreased, it is expected that the in the moment training provided will improve performance overall; (c) Secondary to the TJC survey opportunities for improvement were identified and new procedures were developed to improve communication between staff in the medical clinic and the attending psychiatric and residential nursing staff, including Measures of Success. An annual update with re-education of observers to occur during the first quarter of CY2016; (c) ITRP Outcomes address general medical issues, and are periodically monitored through Medical Executive committee, looking in particular to the degree that appropriate interventions are tied to diagnoses. • Issue 2: Objective 4; Strategy 4: Client Wellness Committee has been reconstituted under new leadership, and is focusing on tobacco cessation training for both clients and staff, with strategies that include: (a) Health Promotion Program that are client centered and consistent with training in Evidence Based Practices received from the Mayo Clinic; (b) intake assessment of tobacco use by newly admitted patients; (c) individualized Tobacco treatment interventions; (c) ongoing group/class presentation on the benefits of Tobacco Cessation; (d) Tobacco Cessation classes for employees, once interest is expressed by 5 to 6 employees; (e) monthly newsletter inserts related to staff education and support; (f) activities in conjunction with the Great American Smoke Out campaign.			
5. Increase successful discharge rate while managing community safety concerns	1. Place geropsychiatry clients through the ADAPT initiative 2. Convert Clinical Operations to Discharge Planning, with set discharge dates for each clinical program	1. Felix Vincenz, Nicole Reitz 2. Lisa Ellis	• Facilitate safe reintegration of clients into the community • Enable admission of clients in need of care at SLPRC
• Issue 2, Objective 5, Strategy 1: Continue to work with ADAPT to discharge geropsychiatry clients appropriate for a SNF environment with additional psychosocial supports. Have a total of 18 referrals, and have discharged 9, with 4 clients pursuing 2 remaining slots, and 2 other clients from SEMMHC being placed. • Issue 2, Objective 5, Strategy 2: Already Completed – Have added tool to identify utilization issues, including clients in cottages			

Objectives	Strategies	Responsible Parties	Anticipated Outcomes
who are not making sufficient progress in treatment to justify a cottage slot, or whose discharge is being impeded by forces outside the client's and hospital's control.			
6. Increase environmental safety	1. Replace carpet with seamless rubber flooring, install ligature proof locksets, and replace the roof in the main building and wards. 2. Shorten lamp cords 3. Install continuous door hinges and ligature proof handrails, cover exposed plumbing, and replace shower heads associated with hanging risk. 4. Install cameras in all client areas, common corridors and parking lots. 5. Installation of sally ports in front lobby, back dock, and secure cottages. 6. Implement recommendations of Security Review Task Force to reduce contraband within the secure perimeter. 7. Reduce risk of loss of perimeter keys by use of proximity readers for entry and exit from all perimeter doors, eliminating use of perimeter keys.	1, 2, 3, 4, 5. Jim Martin 6. Rick Bartell, Jim Cunningham 7. Felix Vincenz	• Reduce fall and infection control risks • Adopt national standards for reducing known ligature risks • Improve safety for both staff and clients by maintaining observation of public areas • Reduce escape risk • Reduce risk to staff and clients associated with contraband • Reduce instances of loss of perimeter keys
• Issue 2, Objective 6, Strategy 1: Have completed the roofing replacement project, although issues with the Metal Roof have been recently identified, impacting the ability to utilize 2 rooms on Ward E. A solution is pending from FMDC; (b) have begun the flooring project, completing floor installation on the clinic waiting room, Wards H and G, and Cottages, A, B, C, D, 5, 7, 10 and 12, and portions of the internral circulating corridor. However, issues with the installation process and product have been identified, requiring us to revisit with FMDC go forward solutions. • Issue 2, Objective 6, Strategy 2, 4, 5, 6 and 7: Already completed • Issue 2, Objective 6, Strategy 3: Already completed - Door hinges, handrails, and exposed plumbing . Have completed a survey of			

Objectives	Strategies	Responsible Parties	Anticipated Outcomes
shower heads and are replacing them as Phases of flooring replacement are completed (all replaced on Ward H). Plan is to complete by June of 2017.			
7. Ensure more adequate and efficient staffing by rebalancing days off for PT1/PT2 staff.	Move 40% of PT1/PT2 staff to Fixed Days Off (FDO) schedule, by moving 40% of PT1s/PT2s to Fixed Days Off schedules, reducing minimal staffing on weekends and excess staffing during the work week.	Felix Vincenz Christian Fox Michael McFarlane	• Reduced use of Overtime on Weekends • More efficient staffing during the workweek • More consistent availability of PT staff as co-facilitators for clinical programming Each of the above, producing and improvement in staff and client safety, as measured by client and staff injuries, reduced restraint usage, and increased in percent of shifts with minimum staffing
• Issue 2, Objective 7, Strategy: (a) Have implemented a revised staffing plan with the requisite Fixed Days Off and Every Other Weekend staffing, rebidding all PTI and PTII positions accordingly; (b) Each Program Nurse Manager will continue to keep weekends balanced, and monitor impact on overtime, including mandatory overtime, ensuring that vacancies are filled to achieve maximal benefit; (c) Revisiting A/B holiday assignments to ensure clarity, equity, and consistency; (d) Reviewing the potential to offer balanced 12 hour shifts for select PTs, with one pilot program on Ward G with 8 such staff.			

Use of Data

Issue Statement #3: Use Data to Inform Practice

1. Ensure transition from Continuous Quality Improvement (CQI) to utilization of Robust Process Improvement (RPI), including Lean, Six Sigma and Change Management	1. QM All performance improvement teams will be chartered using a RPI approach , with a facilitator trained by QM in basic RPI methodologies 2. An RPI champion assists with universal adoption of RPI by staff at all levels in the organization	1. Kris Norris, Tara Yates, Kaelee Newton, Aaron Atkins 2. Kris Norris/ KaeLee Newton	Utilize an established standard of practice in all performance improvement activities
2. Publish key programmatic metrics regarding program effectiveness.	1. QM and Program Director staff will collect data on privilege levels, restraints, hours of active treatment, and cancellation of program activities, and will present monthly reports comparing programs over time to themselves and the facility average. 2. In November of 2016, QM will publish quantitative and survey data to evaluate the success of program realignment that took place in October of 2015.	1, 2 Kris Norris, Kaelee Newton, Aaron Atkins, Program Directors, Felix Vincenz	Provide program staff data that is both meaningful and accessible and that can be utilized to enhance increased programmatic effectiveness

- Issue 3, Objective 1, Strategies 1: (a) Robust Process Improvement (RPI) training was obtained in November, 2015, involving the COO, REO and QI Director in RPI Change Management Techniques; (b) Change Management Tools have been shared with all QM staff and with Executive Committee leadership, which is incorporating them on a trial basis on a project examining opportunities to develop/enhance an overall Culture of Respect and Dignity within the Organization; (c) Articles on High Reliability Organizations have been distributed out of QM; (d) Performance Plan was submitted to the hospital Executive Committee and the Governing Body in the fall of 2016 will included

Objectives	Strategies	Responsible Parties	Anticipated Outcomes
metrics specific to Key Strategic Initiatives selected from the Strategic Plan to move the organization from a more static QA approach to a more dynamic and interdisciplinary QI/PI approach; (e) subsequent to training received in 2016 and 2017, the organization is in the midst of implementing various Yellow Belt DMAIC, Six Sigma and Lean initiatives, with team focusing on [1] client purchasing process; [2] vitals; [2] client budgeting; [3] RN recruitment/retention; (f) In January of 2017, QM staff participated in DMH arranged Green Belt training offered by TJC and is examining how to enhance active treatment hours, and decrease cancellation of program activities; (g) Program Directors provide annual data on privilege levels (see Issue 4, Objective 4, Strategy 2), while QM provides quarterly data on Restraints • Issue 3, Objective 2: Analysis of program realignment has been completed, pending additional data on changes in privilege levels, and All Available Help and Team Supports. No significant differences were observed in discharges, assaults, client/staff injuries, or restraint. However, clients reported increased satisfaction in the following variables: (a) feeling safer; (b) improved quality of life; (c) perceptions of improved staff training; (d) perception of movement toward disarche; and (e) perceptions of ease of movement between minimum and campus security environments.			
5. Utilize Metric Scorecard	At a minimum, all clients will have their progress on one objective on their treatment plan monitored via the Metric Scorecard	Lisa Ellis	Utilize measurable, observable and verifiable data to evaluate progress at the individual client level that can also be aggregated to assess progress at the program and facility level
6. Develop Electronic Medical Record	~~Implement ChartAssist to move toward a community standard of documentation, and to improve our ability to enhance the business intelligence we can extract from our medical record documentation to better inform our clinical practice.~~ Implement Intellidocs through DMH partnership with MetaPharmacy, transitioning to electronic treatment plan and progress note system during CY17	Felix Vincenz Kaelee Newton, Provision of Care	Implement by July, 2017, an electronic version of recovery focused treatment plan and progress notes
• Issue 3, Obj. 5: Pending CY17 • Issue 3, Objective, 6: As a result of contract discussions among the vendor, DMH and OA, a commitment has been to change from ChartAssist to Intellidocs. A steering committee has been assembled and met for the first time in January of this year, with representation including the COO, Clinical Director, and Interim Director of Pharmacy. Leadership is looking for an individual to assume day to day responsibilities for implementation of the EMR, under the local oversight of Provision of Care, with ultimate accountability through the DMH Steering Committee.			

Objectives	Strategies	Responsible Parties	Anticipated Outcomes

Consumer-Oriented Organization

Issue Statement #4: Become more client centric and responsive to the needs and hopes of our clients

Objectives	Strategies	Responsible Parties	Anticipated Outcomes
1. Integrate all clients into organizational planning, policy review and development, and performance improvement activities.	1. All standing committees, CQI teams, and workgroups will include a client representative (exclusive of departmental meetings). 2. Client representatives will be asked to provide input on all facility policies directly impacting client quality of life through the Consumer Council. 3. Develop Consumer Council bylaws to enhance opportunities for client directed care and input into the provision and environment of care. 4. Offer BRIDGES in partnership with Mental Health America.	1. Felix Vincenz, Lisa Ellis, Jim Martin 2. Pam Irving, Karen Pitt 3. Felix Vincenz 4. Phil Dohogne	Accountability to the clients served and inclusion of client perspective in key planning and performance improvement activities
• Issue 4, Objective 1, Strategies 1 - 3: Already completed. Client review of policies through Consumer Council has been added to the policy review process. • Issue 5, Objective 1, Strategy 4: Completed and Ongoing. The Peer Specialist in partnership with Mental Health America has been offering BRIDGES to promote client self-directed services around to enhance opportunities for client directed services, particularly around mental illness education. Clients have the opportunities to graduate and become BRIDGES teachers as an additional employment resource.			
2. Provide current inpatients opportunities to meet with clients who have been successful in their recovery.	1. Utilize the Respect Institute and similar opportunities to allow inpatients access to clients who have progressed toward release. 2. Issue Facility Respect Policy. 3. Hire additional Peer Specialist.	1. Lisa Ellis, Mary Steinhoff 2. Felix Vincenz 3. Lisa Ellis	Enhanced hope in the potential for recovery, promoting greater engagement in the treatment process
• Issue 4, Objective 2, Strategy 1, 2: Already completed • Issue 4, Objective 2, Strategy 3: Completed – Hired 2nd Peer Specialist.			
3. Develop mechanisms for enhancing family involvement in the lives of their loved ones receiving services at St. Louis	Develop one or two family education meetings that are part of the program schedules and afford family members the opportunity to	Jim Mitchell	Family members will have more information about SLPRC's Governing Ideas, its role within the public mental health system, and

Objectives	Strategies	Responsible Parties	Anticipated Outcomes
Psychiatric Rehabilitation Center	obtain information about SLPRC		the nature of the programmatic services being provided their loved ones
4. Enhance Client freedom of movement	1. Expand usage of central courtyard, secure courtyard and patio access for campus security 2. Expand number of clients with Unescorted within Perimeter Privileges and Escorted Community Activities. 3. Celebrate Client Discharge.	1. Felix Vincenz (through Consumer Council) 2,3 Program Directors	➢ Open up central courtyard for usage during all privilege periods ➢ Develop program based protocols for increased time within the secure courtyard and campus security patios ➢ 75% of clients will have either level of privilege

- Issue 4, Objective 3: (a) Kick the Stigma and Family Day events – recurring and ongoing; (b) More formal Family Education activities are still pending as a priority for the next Calendar Year.
- Issue 4, Objective 4, Strategy 1: Already completed
- Issue 4, Objective 4, Strategy 3: This occurs on an intermittent but not formal basis in NOP and SLP, and is being planned for CBP.
- Issue 4, Objective 4, Strategy 2: Completed and ongoing. Current percentages include:

PROGRAM	UNESCORTED WITHIN PERIMETER PRIVILEGES	ESCORTED COMMUNITY ACTIVITIES/ COMMUNITY PASS OR PARTIAL CONDITIONAL RELEASE
CBP	• 48% (12/25) of Ward clients • 100% (17/17) Cottage Clients **69% (29/42) Overall**	• 52% (13/25) Ward Clients • 100% (17/17) Cottage Clients **71% (30/42) Overall**
TRP	**196% (23/24)**	**92% (22/24)**
DSP	**100% (6/6)**	**100% (6/6)**
SLP	• 52% (17/33) of Cottage 8/Ward G • 39% (13/33 of Cottage 6/Ward H **45% (30/67) Overall**	• 45% (15/33) of Cottage 8/Ward G • 30% (10/33) of Cottage 6/Ward H **38% (25/66) overall**
NOP	• 88% (22/25) of Ward Clients • 94% (16/17) of Cottage Clients **93% (39/42) Overall**	• 48% (12/25) of ward clients • 82% (14/17) of cottage clients **36% (15/42) Overall**
TOTALS	**70% (127/181)**	**49% (90/181)**

4. Develop a Recovery Based Treatment Plan	1. Migrate existing problem-based treatment plan approach to a recovery based treatment plan.	Provision of Care	• Clients desired outcomes will be a driving force in our treatment planning approach

Objectives	Strategies	Responsible Parties	Anticipated Outcomes
	2. Building upon Motivational Interviewing, develop a Client Advocate caseload for each non-physician professional of the treatment team to facilitate client selection of desired outcomes		• Clients will formulate their desired outcomes, and will have access to staff who serve as their advocates during the treatment planning process
• Issue 5, Objectives 1 and 2: In preparation for migration to the electronic Medical Record, ChartAssist, the hospital elected to convert from its existing problem focused treatment plan to recovery focused Individualized Treatment and Rehabilitation Plan (ITRP). An ITRP manual was developed by Provision of Care, based on a similar plan already in existence at Fulton State Hospital. A core component of the ITRP process was the development of a Case Advocate approach, in which each non-physician professional served as a client advocate in advance of the scheduled treatment planning meeting, soliciting information from the client on his or her preferred outcomes, objectives and interventions, and serving as the client advocate during the actual team meeting to ensure that the client's perspective and wishes are attended to by the team. Track the impact of this through NRI Stats on client participation.			

Key:

Completed, and/or achieved and ongoing

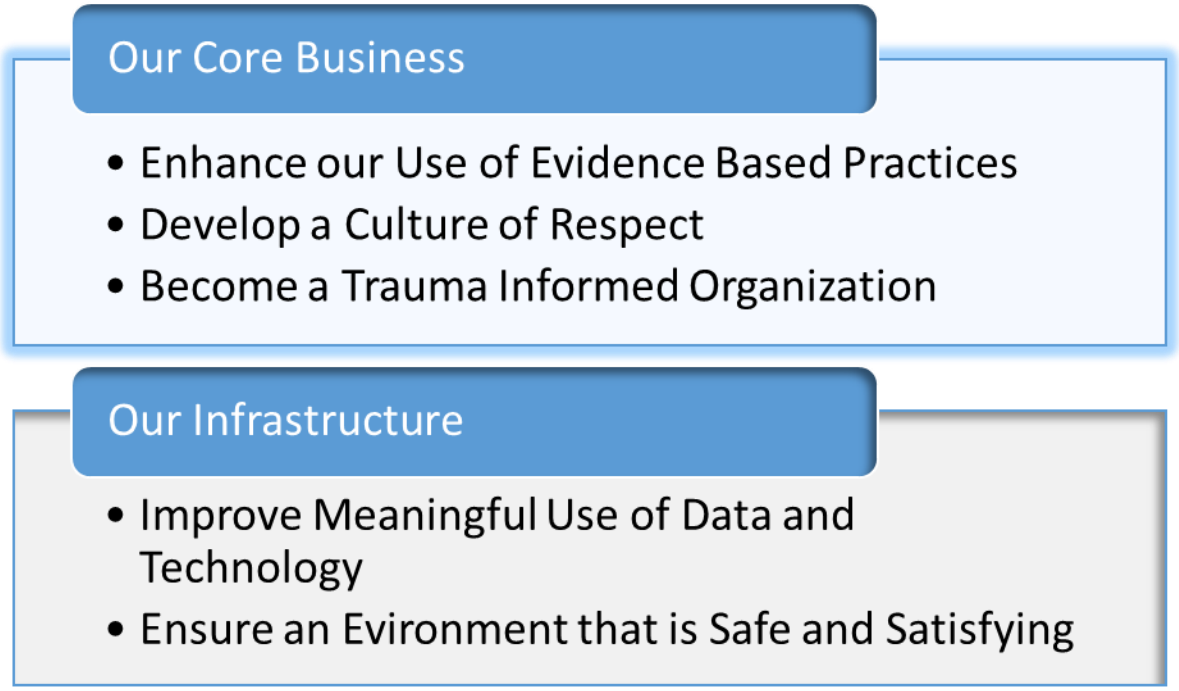
STILL IN PROCESS with Semi-Annual reports to CEC and Facility Leadership

FY 17 – Items not addressed during Current Strategic Planning Cycle, and will be held in review for the next 5 year cycle

Added to the Strategic Plan during this past review cycle. Will convert to orange in year-end report.

Appendix 2: DRAFT STRATEGIC PLAN CY18-CY23

STRATEGIC INITIATIVES



Strategic Initiatives, Objectives, Strategies

CORE BUSINESS

Initiative #1: Enhance our Use of Evidence-Based Practices

Objectives	Strategies	Responsible Parties
1. Increase clients' ability to have access to treatment outside of their program when available and necessary.	1. Enhance communication between programs about the availability of non-program specific treatment modalities (i.e. art therapy, music therapy)	• Program Directors • Team Leaders • Clinical Director
	2. Identify "point person(s)" for existing evidence based treatments (i.e. Responsibility Therapy/TruThought, IPT, etc.) that could be made available for client referral irrespective of program assignment	• Program Directors • Clinical Director
	3. Explore opportunities to incorporate treatment and rehab activities offered by CAT in our treatment planning process, and include them toward our active treatment hours	• Central Activity Therapy Director • Team Leaders • QM Director
2. Develop and Measure Program Specific Outcomes	4. Ensure utilization level expertise in the evidence based practice among all staff assigned to each program (first obtaining training/certification in the practice for program leadership and select numbers of clinicians necessary to provide utilization level training)	• Program Directors
	5. Develop/select fidelity measures to track staff adherence to each program's evidence based practice	• Program Directors
	6. Develop program specific outcome measures consistent with each program's evidence based practice, exploring potential applicability of the Clinical Frequency Recording System (CFRS)	• Program Directors • Clinical Director
3. Enhance our Overall Ultimate Outcomes, with particular attention to work, and independence of living environments	7. Enhance our use of Phase 3 work	• Director of CWP, PDs
	8. Develop more opportunities for in-perimeter work	• Director of CWP
	9. Provide opportunities for older clients to volunteer as an alternative to work	• Director of CWP • Program Directors
4. Enhance Client Wellness	10. Effectively integrate our treatment of our client's physical health with their behavioral health	• Clinic Staff • Medical Director • Chief Nurse Executive

	11. Develop healthier options for canteen purchases	• Volunteer Director
	12. Provide healthier lifestyle interventions by program	• Program Directors
	13. Develop client wellness committee with client representatives from each program.	• Chief Operating Officer • Wellness Committee
5. Enhance implementation of IDDT and Motivational Interviewing	14. Measure if Substance Use Assessments (SUAs) are being completed on time	• HIMS Director
	15. Develop supports for programs admitting clients from community with recent Substance Use relapse	• IDDT Learning Community
	16. Education from IDDT Learning Community on how to integrate IDDT information into existing program based groups	• IDDT Learning Community
	17. Increase client access to community based 12-Step recovery meetings in consultation with SLPRC DRA facilitators; including linkage to sponsors	• Program Director • Freedom Bound • Rachel Linneman
	18. Utilize Case Western IDDT Fidelity tool	• IDDT Learning Community
	19. Explore options regarding more education and training refresher, including practice of MI skills	• IDDT Learning Community

Anticipated, Measurable Outcomes

1. Increased Active Treatment hours	2. Treatment matched to diagnoses
3. Measurable fidelity to all programs	4. Increased clients interacting in the community
5. Clinic staff attending treatment team meetings	6. Treatment plans accurately reflecting client physical health issues
7. Overall better health outcomes	8. Decreased medical costs incurred by facility
9. Establishment of Client Wellness Committee	10. IDDT and MI implemented and utilized within each program
11. Fewer readmissions due to substance abuse relapse	

Key Successes (For Regular Reviews of our Strategic Plan Progress)

PROCESS • Objective 1, Strategy 1 & 2: • Objective 2, Strategy 3:
OUTCOME • Outcome 1:

Initiative #2: Develop a Culture of Respect

Objectives	Strategies	Responsible Parties
1. Enhance our efforts to engage and involve our staff at all levels of the organization	1. Ensure integration of PTs, in treatment team meetings, program meetings, and key hospital committees	• Program Directors • Team Leaders • Chief Operating Officer
	2. Improve the engagement and integration of nursing professionals and psychiatric technician staff in the delivery of psychotherapy and psychoeducational treatment, providing opportunities for training and competency development as needed.	• Program Directors • Team Leaders • Program Nurse Managers
	3. Schedule meetings at all levels in our residential areas – whether treatment team, programmatic or administrative meetings – to facilitate engagement with and involvement of our PTs, ensuring that their opinions are actively solicited.	• Program Directors • Team Leaders • Chief Operating Officer
	4. Enhance our on-boarding process to have every new employee is welcomed by supervisory staff (e.g., PT2, RN, Team Leader), oriented to the residential area/department, oriented to the PERforM and their PDF, and asked as to their career progression interests and goals, revisiting this during the probationary process, and at a minimum of once annually thereafter.	• Human Resource Director • Program Directors • Department Directors
	5. Ensure that all newly hired nursing staff and psychiatric technicians spend a minimum of one day shadowing non-nursing treatment team members, program directors, and/or team leaders to promote team coherence	• Human Resource Director • Chief Nurse Executive • Program Directors
	6. Ensure staff members from all departments on a rotating basis will attend Patient Safety Meeting daily	• Program Directors
	7. Provide a monthly gathering opportunity for two departments from the hospital to meet and socialize to promote an environment of cohesion across all departments	• Program Directors • Department Directors
2. Enhance the profile and presence of our Respect Institute Program	8. Ensure that Respect Institute speakers attend treatment team meetings monthly at minimum	• Pastoral Services Director • RESPECT Coordinator
	9. Provide bi-annual all-facility events to give opportunities for new Respect Institute members to practice speaking	• Pastoral Services Director • RESPECT Coordinator

3. Demand respect in all interactions involving employees or clients, with a particular commitment to respectful behavior from individuals in supervisory positions	10. Ensure all staff entering into supervisory positions receive a basic supervision training (e.g., SOS training), and actively exposed to supervisory training offered through OA-DoP.	• Human Resource Director • Program Directors • Department Directors
	11. Encourage individuals who are on a leadership track to participate in the DMH leadership academy.	• Human Resource Director • Program Directors • Department Directors
	12. Ensure all supervisory staff attend annual continuing education seminars to promote knowledge of management theory and utilization of theory in practice	• Human Resource Director • Program Directors • Department Directors
	13. Ensure that information about disrespectful client-staff or staff-staff interactions that do not warrant EMT is disseminated via email from the observer/victim to each supervisor, with a response from supervisors to be given within 48 hours.	• Human Resource Director • Program Directors • Department Directors
	14. Continue our efforts to more broadly utilize and apply the Excellence Algorithm, and train supervisory staff in its application.	• Chief Operating Officer • Program Directors • Department Directors
4. Become more client centric	15. Ensure that our clients have access to Client Advocates in advance of all treatment planning meetings	• Team Leaders
	16. Explore the potential to utilize WRAP in our treatment planning	• Provision of Care Committee • Peer Specialist
	17. Expand our efforts to include families as partners and participants in treatment planning and delivery	• Program Directors • Director of Social Work
5. Improve our efforts at recruitment and retention, reducing in particular our turnover rates for PTs and RNs	18. Reduce time from application to employment for all clinical staff by providing fingerprinting and drug testing for new employees on the SLPRC campus	• Human Resource Director • Department Heads
	19. Develop social media strategies for recruitment and retention	• Chief Operating Officer • Human Resource Director

	20. Ensure that exit interviews (including the exit form) are completed, and that HR employees complete the exit form based on information obtained during the exit interview should the employee decline to complete the form	• Human Resource Director
	21. Ensure that staff from departments of social work, psychology, and nursing attend job fairs annually at UMSL, SLU, Maryville University, SIUE, and WashU, with a particular focus on social work, psychology, and hospitality	• Department Heads
	22. Ensure contact with Deans at UMSL, Mavyille University, SLU, SIUE, and WashU – with a particular focus on psychology, social work, and hospitality – to schedule student tours each semester in order to promote both hiring and obtaining interns	• Department Heads

Anticipated, Measurable Outcomes

1. Meetings with PTs	2. Exit Interview and Exit forms
3. Paperwork/email documentation of employee complaints of disrespect	4. Inpatient consumer surveys
5. Schedule and sign-in sheets for monthly inter-departmental gatherings	6. Data results of tracking employee turnover, rates of hiring, and employee vacancies in each department
7. Reports from employees regarding presence/absence of interventions	8. Reports from employees regarding family involvement in treatment planning meetings

Key Successes (For Regular Reviews of our Strategic Plan Progress)

PROCESS • Objective 1, Strategy 1 & 2: • Objective 2, Strategy 3:
OUTCOME • Outcome 1:

Initiative #3: Become a Trauma-Informed Organization [REDIRECT TO TIC STEERING COMMITTEE]

Objectives	Strategies	Responsible Parties
1.	1.	•
	2.	•

Anticipated, Measurable Outcomes

	1.

Key Successes (For Regular Reviews of our Strategic Plan Progress)

PROCESS

- Objective 1, Strategy 1 & 2:
- Objective 2, Strategy 3:

INFRASTRUCTURE

Initiative #4: Improve Meaningful Use of Data and Technology

Objectives	Strategies	Responsible Parties
1. Implement an Electronic Medical Record	1. Reduce redundancies among our assessments	• EMR Steering Committee • Medical Records Committee • Medical Staff
	2. Ensure effective integration of assessments, with treatment plans, client schedules, and progress notes	• EMR Steering Committee • Medical Records Committee • Medical Staff
	3. Provide effective data entry tools to our Psychiatric Technicians for documentation and communication with the rest of the team, including messaging functions	• EMR Steering Committee • Medical Records Committee • Medical Staff
	4. Ensure the EMR provides the means to effectively integrate medical information from the clinic and external medical providers, with the balance of the treatment team	• EMR Steering Committee • Medical Records Committee • Medical Staff
2. Better celebrate our successes and ensure that these are more effectively communicated both within and outside our organization	5. Develop an easily accessible and understandable dashboard viewable on Sharepoint site (AKA SLPRC intranet) and through Social Media. Metrics to consider include: (a) staff satisfaction; (b) length of stay; (c) successful placements in the community/quarter; (d) client injury rate; (e) staff injury rate; (f) active treatment hours; (g) recreational/leisure hours; (h) hours in community working; (i) percentages of clients with Unescorted Privileges/Escorted Community Activities; (j) client satisfaction (with supplemental questions beyond the NRI instrument); (k) hours of restraint, percent of clients restrained, days without restraint	• Director of QM (t) • Social Media Coordinator • ERRC
	6. Explore potential markers for physical health	• Medical Director
	7. Use of Social Media to be an effective presence in the community, to educate the community about what we do, for assistance with recruitment and retention, including outreach to our university partners	• Chief Operating Officer • Social Media Coordinator
3. Develop tools for facilitating communication across shifts,	8. Tools for effective communication regarding the out-trip calendar, clients involved, and out-trip resources (e.g., access to vehicles)	• Director of Rehab Services • SPD Director

programs and departments, reducing the silos that divide us	9. Effective use of Social Media to communicate facility announcements, changes in policies and practices, etc.	• Chief Operating Officer • Social Media Coordinator
	10. Install monitors in the lobby, in the canteen alcove, and in the dining room as an additional site for announcing: (a) winners of Employee of the Month/Year, Respect Champions, and High Five recognition; (b) general messages from leadership, redirecting individuals to our Social Media site for more information; (c) metrics for the facility performance	• Chief Operating Officer
	11. Ensure clinic staff attendance at the treatment team	• Medical Director (t)
	12. Establish a standard meeting calendar viewable to all staff, bringing more coherence to the scheduling of treatment teams, program meetings, and hospital committees, etc.	• Executive Administrative Assistants (t)
	13. Explore options for use of electronic signature processes to expedite the approval process across departments and programs	• Chief Operating Officer

Anticipated, Measurable Outcomes

1. Successful implementation of an EMR by December 1, 2018	2. Number of team meetings with clinic attendance
3. Presence/absence of established dashboard on a Social Media Site	4. Presence/absence of monitors in lobby, dining rooms, and canteen alcove
5. Presence/absence of calendars for meetings	6. Presence/absence of calendars for out trips

Key Successes (For Regular Reviews of our Strategic Plan Progress)

PROCESS • Objective 1, Strategy 1 & 2: • Objective 2, Strategy 3:
OUTCOME • Outcome 1:

Initiative #5: Ensure that our Physical Environment is both Safe and Satisfying

Objectives	Strategies	Responsible Parties
1. Reduce ligature risks	1. Replace sinks, shower valves, and non-ligature resistant grab bars	• FMDC • Chief Operating Officer • Chief Financial Officer
	2. Develop ligature resistant solutions for interior doors in client bedrooms, bedroom doors, and bathroom stalls	• FMDC • Chief Operating Officer • Chief Financial Officer
	3. Modify policies specific to client stabilization and transfer for clients who present a risk of suicide as determined by the Suicide Assessment	• Chief Operating Officer • Clinical Director
2. Develop a biometric solution for our Client Check-In process	4. Check in system for clients using fingerprints similar to our rounds.	• Chief Operating Officer • Director of Purchasing • OA-ITSD
3. Enhance our cottage environments	5. Replace aging roofs, metal flashing, patio doors	• FMDC • Chief Operating Officer • Chief Financial Officer
4. Enhance parking lots and sidewalks	5. Paint the lines, fill in the holes, add additional lights, trim/remove the trees.	• FMDC • Chief Operating Officer • Chief Financial Officer
6. Reduce over-stimulation and associated incidents secondary to elevated sound levels with new flooring	6. Develop sound mitigation solutions for our rubber flooring	• Hospital Management Assistant • Environment of Care Council
7. Develop more effective transportation options	7. Availability of transportation solutions after 3 pm for outside medical visits, sitters at outside hospitals. This will include exploring options for use of contracts for taxis, Uber/Lyft.	• Motor Vehicle Staff • Director of Purchasing

Anticipated, Measurable Outcomes

2. Reductions/no successful suicide attempts/completed.	3. Reduced number of environmental and appliance damages from the roof leaks.
4. Reduce overtime costs, staff dissatisfaction, and client incidents associated with unnecessarily prolonged outside visits due to	5. Reduced incidents, workman's comp costs and overtime costs associated with injuries secondary to falls associated with parking

transportation difficulties	lots and sidewalks
6. Reduced level of noise on the units	7. Comply with TJC and CMS standards for suicide assessments

Key Successes (For Regular Reviews of our Strategic Plan Progress)

PROCESS • Objective 1, Strategy 1 & 2: • Objective 2, Strategy 3:
OUTCOME • Outcome 1:

Key for Future Reporting Periods or Review Cycles

Completed, and/or achieved with no need for ongoing monitoring or reporting.
STILL IN PROCESS or MONITORING REQUIRED with Semi-Annual reports to the workforce
No Progress to date, but will be retained in the plan for future implementation and review, either in current or future Strategic Planning Cycles
Added to the Strategic Plan during this past review cycle. Will convert to orange in year-end report
~~Strikethrough~~ – Deleted as no longer deemed a meaningful component of the current Strategic Planning Cycle